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Measurement and meaning of Core Relationship Theme changes during psychotherapy

Lisa Parker
University of Wollongong

Measurement and meaning of Core Conflictual Relationship Theme changes during psychotherapy

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Lisa Parker

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Thesis Certification

I, Lisa Parker, declare this thesis, submitted in partial fulfilment of the requirements for the award of Doctor of Psychology (Clinical) in the Department of Psychology, University of Wollongong, is wholly my work unless otherwise referenced, or acknowledged. The document has not been submitted for qualifications at any other academic institution.

Lisa Parker

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Abstract

Through the investigation of two related Core Conflictual Relationship Theme (CCRT) methodologies, this study continued to contest the notion the field of psychoanalysis is bereft of empirical ventures. The Quantitative Assessment of Interpersonal Themes (QUAINT) and Core Conflictual Relationship Theme – Leipzig/Ulm (CCRT-LU) systems were applied to psychotherapy transcripts from the treatment of seventeen patients who had attended multiple sessions per week of long-term psychoanalysis. The thematic profiles of each method were modified to facilitate a direct comparison of the methodological structures, including the coding system. The investigation reported on the strengths and weaknesses of each system. The QUAINT and CCRT-LU methods were fair-to-moderately related (overall kappa: .34). The CCRT-LU system showed greater concordance to the tailor-made method, which marks the 'gold standard' of the CCRT methodologies. Therefore, the CCRT-LU system was then selected to illustrate the interpersonal relationship pattern changes of the patients engaged in long-term psychoanalytic psychotherapy. These relational patterns were related to several outcome measures such as the Mastery Scale, the Global Assessment of Functioning and the Health Sickness Rating Scale. Patients' relational patterns evidenced significant changes over therapy, particularly on the Response of Self component, and the valence of their interpersonal conflicts shifted significantly to more positive and harmonious outcomes. As predicted, these effects were most noticeable for those patients who had been assessed as 'most-improved' by their Mastery Scale scores. Both CCRT methods were demonstrated as valid and reliable research tools capable of appraising the maladaptive relational patterns of patients engaged in long-term psychoanalysis.

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Chapter 1

Introduction

Psychotherapeutic approaches will continually benefit from accumulated understandings of the intricate dynamics that occur within therapy. This is especially the case as these dynamic interactions collaboratively propel the patient toward therapeutic goals, whilst simultaneously providing the therapist with understandings that will not only benefit the patient but also contribute to the evolution of psychotherapy theory. French articulates: "Psychoanalytic therapy is not only an intuitive art. We should try to convert it into a scientifically oriented procedure" (1958, p.3). The task of negotiating the numerous elements of psychoanalytic therapy, from the research perspective, has been challenged by the diversity of thought among the various schools of psychoanalytic theory as exemplified by Dreher's (2002) discussion on the aims of psychoanalysts. Furthermore, the dilemmas of scientific methodology (Luborsky, 2000; Roth & Fonagy, 1996; Roth, Fonagy & Parry, 1996; Wampold, 1997), such as the reliance on the clinical case study (Leuzinger-Bohleber & Target, 2002), have also confounded the development of psychoanalytic research, which in the opinion of McWilliams was not encouraged by Freud's "dismissive attitude toward empirical research" (p.9, 2004). Nevertheless, Freud was renowned for his commitment to ensuring psychoanalytic practices had a scientific foundation (Thomä & Kächele, 1987).

Under the pressures of evidence-based medicine (Bornstein, 2003; Fonagy, 2004), the professions' seeking of credibility (Leuzinger-Bohleber & Target, 2002) and the public's demand for knowledge of effective interventions (Barber, Crits-Christoph & Morse, 1995), psychoanalytic research has progressed beyond the clinical case study.

Psychoanalytic research currently operates in a generation of psychotherapy research that produces studies that have been conducted prospectively, systematically and with methodological approaches to both outcome and process aspects of psychoanalytic and psychoanalytic-psychotherapy (Wallerstein, 2001). Wallerstein (2001) alludes to the close proximity of the next generation of psychotherapy research that effectively encompasses the intricacies of outcome and process studies. This thesis through its investigation of several Core Conflictual Relationship Theme methodologies, seeks to engage with these principles of psychotherapy research.

The Core Conflictual Relationship Theme (CCRT) as a measure of personality or relationship style is a systematic guided formulation that is capable of producing reliable clinical judgments that are amenable to empirical investigations (Luborsky, 1998a). Luborsky's CCRT methodology, which was discovered during investigations into the therapeutic alliance (Luborsky, 1976) and grew from a clinician's effort to systematically derive interpretations from patient's narratives (Luborsky, 1998a), has been cultivated within the field of psychodynamic psychotherapy research to facilitate the development of theory relevant clinical research. Because all "therapists, of whatever persuasion, carry a personality theory into the consulting room" (Bornstein & Masling 1998, p.xxiv) it is imperative in the current scientist-practitioner climate to have relevant theory-driven measures. This study adopts a data set that is congruent with the theory of the therapy (i.e., psychoanalytic). It is the intent of this research to investigate methodological issues by comparing two related but divergent methods: the Core Conflictual Relationship Theme - Leipzig/Ulm (CCRT-LU) (Albani, Benninghofen et al., 1999; Albani et al., 2002) method and the Quantitative Assessment of Interpersonal Theme (QUAINT) method (Baranackie & Crits-Christoph, 1992; Crits-

Christoph, Demorest, Muenz & Baranackie, 1994; Connolly, Crits-Christoph et al., 1996; Crits-Christoph, 1998). This study also will examine CCRT methods through an exploration of the relationship between the CCRT system and clinical outcome measures and through the change of relational patterns over the course of therapy.

In a science that relies heavily on inferences to assert 'knowledges', constructs and metaphors have often been adopted as the means by which psychologists, in both clinical and research settings, understand psychological phenomenon. The construct integral to the CCRT method is that of a central relationship pattern. This concept can be traced through a lineage that crosses various theoretical perspectives and generations of research (Luborsky, 1998a). At the time of its inception, Luborsky noted the resemblance between the core conflictual relationship theme and Freud's concept of the transference template (Luborsky, 1998a). The significance of this resemblance cannot be underestimated. The concept of transference has been imbued with contention due to its origins in Freud's frequently regarded dubious ideologies (McWilliams, 2000). Any scepticism directed at Freud's notions were thought to be warranted due to his turning "away from the careful empirical methods he used in the laboratory toward generalisations without presenting raw data" (Bornstein & Masling, 1998, p.xviii). It may be argued Freud's 'raw data', derived from the discourse that occurred in his consulting room and reflected in his prolific writings, facilitated the development of conceptual representations of psychological phenomenon (Bornstein & Masling, 1998). This argument is reflected in Bucci's assertion that "Freud's agenda was the construction of a theoretical device, a 'psychical apparatus', which accounted for maladaptive functioning and its repair in treatment" (2000, p. 204). The task for psychoanalytic/psychodynamic therapy researchers has been to devise theoretically

informed empirical methodologies that evaluate process and outcome variables of therapy (Wallerstein, 2001). Hence, the resemblance between the CCRT and transference parallels a "transformation of a useful clinical concept into an even more useful clinical quantitative measure" (Luborsky, 1998a, p. 5). The research forms a "third generation" of psychoanalytic development, consisting of testable research questions and tools, which followed from the first generation of early pioneers and the second generation of clinicians disseminating the early ideas.

The psychodynamic theorists draw on Freud's concept of transference to explain those aspects of the patient's personality that contribute to the manifestation of symptoms. Freud (1912/1958) conceptualised the basis of transference as being derived from the individual's unique character and the influences of early experiences, which in turn informs the persons system of satisfying one's aspirations, known as 'stereotype plates'. In this context, personality refers to the individual's relationship style which consists of the persons mental representations of interpersonal relationships and the associated wishes and affects (Crits-Christoph et al., 1994). These mental representations are synonymous with Freud's stereotype plates and therefore are inclusive of the key characteristic of transference which includes: one main pervasive pattern; origins in early parental relationships; partly unconscious; wishes conflict with responses from other and of self; positive and negative patterns are distinguishable; improvement is indicative of mastery of the patterns; and related to the expression of symptoms (Luborsky, 1998d). Other theorists have accounted for similar phenomenon across the psychoanalytic traditions. For example, Blos (1941) speaks of *residual trauma* and French (1958) coined the term *nuclear conflict* to convey concepts of a central relationship pattern (Luborsky, 1998a). Luborsky cites Arlow (1969a, 1969b),

also of the psychoanalytic school, who not only captured the essence of a central relationship in his writings but also the aspect of its being unconscious (Luborsky, 1998a). Early psychoanalytic outcome studies observed the persistence of conflictual relationship patterns beyond the end of analysis. The conclusion that transference is not removed during treatment challenged early beliefs that a reduction in transference indicated successful analysis (Luborsky, 1998a).

Luborsky (1998a) refers to the interest in a central relationship pattern as pursued by personality researchers such as Murray's (1938) *unity-thema,* Kelly's (1955) *Role Construct Repertory* and Tomkin's (1987) *nuclear script.* In particular, Murray suggests that ". . . thema may stand for primary infantile experience or a subsequent reaction formation to that experience. But, whatever its nature and genesis, it repeats itself in many forms during later life" (Murray 1938, p.604-605). Thus far it would appear both clinical and personality theoretical perspectives agree that the phenomenon they have respectively sought to understand, share two common features: one, there is a central, repetitive relationship theme that, two was formed from early childhood experience. Other theoretical orientations share similar ideas. For example, script theory observes an enduring set of relationship patterns that are repeated throughout a person's life (Young, Klosko & Weishaar, 2003). Luborsky also identified commonalities between the CCRT's response of other concept and the opinions expressed by the social psychologist, Heider (Luborsky, 1998a). According to Luborsky, Heider held the view that people need to "form concepts of their relationship environment" (Luborsky, 1998a, p. 8). As one steps into Heider's book, *The Psychology of Interpersonal Relations*, one immediately observes a resemblance to aspects of the CCRT: "Generally, a person reacts to what he thinks the other person is

perceiving, feeling, and thinking, in addition to what the other person may be doing. In other words, the presumed events inside the other person's skin usually enter as essential features of the relation' (Heider, 1958, p.1). Similarly, the CCRT method seeks to capture the patient's view of the expected or actual responses of other people in context of trying to create changes in their relationship with others (Luborsky, 1998a).

According to the psychodynamic theorists the mental representations of interpersonal relationships are based on past relationship experiences and are applied to guide interactions in current relationships (Crits-Christoph et al., 1994; Luborsky, 1998a; Luborsky, 1998d). In the event that the core theme is conflictual or maladaptive, the person is likely to manifest psychological symptoms (Crits-Christoph et al., 1994). Clinicians have noted that patients who have fixed and resistant to change maladaptive relationship patterns have poor prognosis and outcome (Grenyer & Luborsky, 1998). Those writers in the social-cognitive field employ the concept of 'schema', as originated by Piaget, and assert that people will 'select' a schema specific to the situation they are in or that external triggers will elicit a particular schema (Crits-Christoph, Demorest & Connolly, 1990; Crits-Christoph et al., 1994). More recently researchers working with the CCRT method (Crits-Christoph et al., 1994) have observed how it is noticeably similar to cognitive therapy concepts such as the numerous aspects of 'organised memory structures' (schemas, prototypes, scripts etc) (Singer & Salovey, 1991) and repetitive maladaptive relationship patterns (Westen, 1991).

The cognitive and psychodynamic theoretical perspectives agree people have mental representations of relationships that inform how they interact with people. Where the theories diverge relates to the pervasiveness of relationship themes. The psychodynamic writers notice the schemas in pathology and assert the occurrence of a

single pervasive theme whereas the social cognitive researchers, based on investigations in laboratory settings, attest the situational specificity of themes which implies multiple themes (Crits-Christoph et al., 1994). There is disagreement within the ranks of psychodynamic theorists as some suggest multiple themes manifest within specific situations (Crits-Christoph et al., 1994). Horowitz (1991) attests the possibility several schemas may be activated within a particular context, which is attributable to when a situation triggers both an *enduring schema* and a *working through* schema. Luborsky may not disagree with the manifestation of multiple themes; however he places a clinical and research emphasis on a *central* theme being pervasive across interpersonal interactions (Luborsky, 1998a). McWilliams' (2004) discussion on psychoanalytic sensibilities reflect on the curiousness of the relationship choices people make that repeat relational patterns and the complexity or multiplicity of intra-psychic conflicts. Crits-Christoph et al. propose the "notion that a patient may demonstrate mainly one core conflictual relationship theme is likely to apply only to a subset of patients, those with greater pathology or who have a particularly restrictive or severe set of interpersonal experiences in their development" (1994, p.504). This proposition is often substantiated by observations that some patients are restricted in their interpersonal relationship experiences by rigid character structures (Koenigsberg et al., 2000; McWilliams, 2004; Meares, 2000). In summary, multiple relational themes pervade patient's narratives of interpersonal experiences. The task of the clinician is to appraise the patient's narrations and exclude those that appear redundant and to work through those relational themes that are dominant and the probable cause of symptomatic distress for the patient. The task of the researcher is to ensure the methodological systems parallel such therapeutic practices. Further research is required to clarify these issues.

1.1 Measuring Relationship Themes

Luborsky's review of the CCRT lineage exposes the lack of research investigating the central relationship pattern and the apparent neglect by academic psychology to devise relevant operational methods to study this common clinical phenomenon (Luborsky, 1998a). From his own work, Luborsky has established a set of criteria with which to form operational methods. In order to conform to requirements of empirical rigor, these criteria ought to ensure the method is guided by principles of clinical and quantitative judgement and is applied to samples of patient's narratives of interpersonal interaction. Furthermore, this process must reliably identify core relationship patterns (Luborsky, 1998a).

The possibility of measuring relationship themes within the therapeutic environment, regardless of psychotherapeutic modality, has been facilitated by the development of the Core Conflictual Relationship Theme (CCRT) method. Luborsky, Crits-Christoph, Mintz and Auerbach state:

> It is clear that the major stumbling block to the development of an outcome measure suited to the evaluation of outcomes of psychoanalytic psychotherapy has been the lack of a reliable and valid measure of the nature of the patient's particular dynamic conflicts and themes. Without a measure of the relevant conflicts for each patient, researchers cannot determine whether improvement that is consistent with the theory and techniques of the therapy has occurred. (1988, p.251-252)

Essentially, Luborsky and colleagues are advocating a theory-relevant measure of psychodynamic change. Several theoretical phenomena that permeate transference have been investigated using the CCRT methodology. For example, the CCRT method is capable of producing relational themes that can be analysed to determine characteristic patterns, such as pervasiveness (Connolly, Crits-Christoph et al. 1996; Crits-Christoph and Luborsky 1998); thematic profiles matched to objects (Fried, Crits-Christoph & Luborsky, 1998; Connolly, Crits-Christoph, Barber & Luborsky, 2000); and, psychoanalytic processes (Albani et al. 2003).

1.1.1 Pervasiveness

Crits-Christoph and Luborsky (1998) investigated the pervasiveness of relationship conflicts based on the premise that relationship conflicts are the instigators of symptoms. Pervasiveness is evidenced by the frequency that the relationship conflicts occur across narratives about interpersonal interactions. In the CCRT calculation this means a decrease in the percentage of relationship episodes in which the conflictual theme is evident. Therefore, they suggest that an index of change in dynamic therapy is the reduction of maladaptive themes over the course of therapy; that is, the maladaptive theme becomes less pervasive (Crits-Christoph & Luborsky, 1998). Their study found a small but consistent reduction in the pervasiveness of the main conflictual relationship pattern, and their results also revealed patterns of changes from early to late treatment, in particular the wish component changed less than the response from other [RO] and response of self [RS] components (Crits-Christoph & Luborsky, 1998). This invites the conclusion that the wish is more robust and that the expectation about others supporting or blocking the wish are more flexible; therefore in therapy the theoretical curative factor rests in the patient learning to recognise and cope with the

wish response to produce more positive and less negative reactions (Crits-Christoph & Luborsky, 1998). Crits-Christoph and Luborsky concluded these findings support the theoretical view that even in successful therapy conflicts are still evident however some components have changed (1998).

Freud maintained "a stereotype plate (or several such), . . . is constantly repeated . . . in the course of the person's life" (1912/1958, p.100). Crits-Christoph, Demorest and Connolly engaged in this debate regarding the singularity or multiplicity of transference themes (1990). This study utilised a quantitative methodology based on Luborsky's CCRT structure, to examine the similarities and pattern of the transference theme across a particular patient's relationships, including the one with the therapist. This study adopted a single case, "Mr B.", who had attended 31 psychotherapy sessions for the treatment of a problematic grief reaction. Each session was tape recorded and transcribed verbatim. The findings suggested that different interpersonal themes emerge from different types of relationships and that negative transference featured most toward the second phase of therapy, after an initial period of positive transference (Crits-Christoph et al., 1990). In other words, profiles can be similar across some relationships but different with others and that the profiles change over the course of therapy. These findings confer with the theoretical view proposed by Horowitz and colleagues that relationship themes are both multiple and complex (Crits-Christoph et al., 1990). Barber, Foltz, DeRubeis and Landis investigated the consistency of interpersonal themes both across different relationships and across various interactions within specific relationships (2002). In spite of the methodological issues, such as the use of RAP interviews rather than therapy sessions, the use of clinically naive judges and the scoring of relationship episode within the transcript rather than the extracted RE

as is done in the QUAINT system; the results challenged the existing notion that the central relationship pattern is an ubiquitous phenomenon (Barber, Foltz, DeFubeis & Landis, 2002).

Further investigations into the theoretical issue of singularity and multiplicity of relationship themes was conducted on a larger sample (Connolly et al., 1996). This study was interested in whether the main pattern apparent in the therapeutic relationship was the predominant pattern for all patients; and at what stage in therapy might transference emerge. Their findings offered the following conclusions: (1) interpersonal patterns are both complex and multiple; (2) the profile of wishes, responses from other and response of self in the therapist/patient relationship were uncorrelated with the interpersonal relationship profiles between the patient and significant others; and, (3) negative transference is most apparent during the second half of therapy following an initial phase of positive transference (Connolly et al., 1996). Recommendations suggested the need to examine transference in a more traditional patient population and be able to obtain data across different phases, at least early and late therapy (Connolly et al., 1996). Additional advice proposed an exploration of the intricacies of transference by first delineating the nature of transference, then comparing repetitive interpersonal themes to themes that are idiosyncratic to specific significant relationships, including the therapist (Connolly et al., 1996).

Continued investigations of the transference construct focused on the therapist's influence on the report of interpersonal themes and how transference varies over the course of psychotherapy (Connolly et al., 2000). The central tenet of psychodynamic psychotherapy, that patients form maladaptive relationship patterns early in childhood that will in turn produce problems in adult relationships, was examined. This group of

researchers identified that no research has been conducted to demonstrate the theoretical assertion that interpersonal themes should be associated with evidence of psychopathology (Connolly et al., 2000). The results from their study suggest that patient's interpersonal themes do not necessarily transfer to the therapeutic relationship in short term therapy (Connolly et al., 2000). The results were consistent with previous findings (Connolly et al., 1996) that only 34% of patients displayed their most pervasive interpersonal theme to the therapeutic relationship (Connolly et al., 2000). When transference of interpersonal themes to the therapeutic relationship was evident, is was usually the core or most pervasive theme (Connolly et al. 2000).

The traditional psychodynamic theoretical stance that single relationship themes are pervasive has been partially supported by investigations of the pervasiveness using the core conflictual relationship theme method (Crits-Christoph & Luborsky, 1998). Even though the CCRT method has been demonstrated as reliable and valid, researchers have devised alternate structures and methodologies to refine the responsiveness to clinical processes; to honour the relatedness to theoretical positions; and, to strengthen empirical characteristics.

1.2 Methodological Perspectives

Within the field of psychodynamic psychotherapy research, the Core Conflictual Relationship Theme is widely used with over 100 studies currently being conducted to explore and assess its validity (Grenyer, 2002). Numerous CCRT methodological developments have occurred to affect sensitivities to the clinical material and to achieve empirical robustness (Crits-Christoph, 1998). The following section will describe the original tailor-made method, which is the CCRT benchmark. This will be followed by discussions of three coding systems that are applied to the tailor-made method, the

Standard Categories, the QUAINT and the CCRT-LU systems. Valence, which captures the positivity and negativity of transference phenomenon, is also described.

1.2.1 Core Conflictual Relationship Theme-Tailor-Made Method

Luborsky recalls his reflexive process of attending to the patients narratives about their interactions with other people as well as with himself as the therapist. Specifically, he comments how he was most interested in those narrated interactions that recurred and what the patient wanted from other people, how the patient reported their response and how the patient reacted to the response (Luborsky, 1998a). Luborsky, in his recount of the development of the CCRT method, reflected on how he noticed a resemblance to Freud's concept of the transference template in that it "behaved much as many experienced psychodynamic clinicians do in making their usual inferences in formulating transference patterns" (1998a, p.4). Luborsky formulated these essential observations to illustrate three facets of patient's interpersonal narratives: the types of wishes, needs and intentions concerning the other person [W]; the perceived response from the other person [RO]; and, the response of self [RS] (Luborsky, 1998a). These components are applied to the relationship episode [RE], which is a discrete portion of the therapeutic transcript that captures the patients' narrative regarding another person or themselves. This process will produce a tally of each component across a number of relationship episodes both within a single therapy session and across many treatment sessions. The highest occurring formation of components constitutes the core conflictual relationship theme - the CCRT (Luborsky, 1998a). In short, this encompasses Luborsky's reliable method of guided inferences about the patient's central relationship pattern. The tailor-made method adheres to the patient's expression; hence it is most sensitive to clinical processes (Barber, Crits-Christoph & Luborsky, 1998;

Luborsky, 1998b). Due to the variability of language both within a single patient but especially across a large sample of patients, the tailor-made system is limited in the research arena least of all because of the inability to derive reliability estimates from non-standardised expressions.

1.2.2 Core Conflictual Relationship Theme-Standard Categories

Standard Categories were introduced to overcome the research limitations of the tailor-made method by way of providing a 'dictionary' that removes "the ambiguities by requiring that all judges apply the same category to the narratives so that comparison between judges is simplified" (Luborsky, 1998b, p.26). Therefore, the standard categories eliminate discrepancies in the judges scoring and thereby aid reliability (Barber et al., 1998). The Standard Category method can either rely on a translation of inferences determined in the tailor-made method into the standard category or alternatively, the standard categories can be applied directly to the patient's narratives (Luborsky, 1998b). The former of the two methods is recommended due to its versatility and richness of information (Barber et al., 1998; Luborsky, 1998b). There are three editions to the standard categories: Edition 1, Standard categories were derived from a normative sample of 16 cases; the Edition 2, Expanded standard categories resulted from an expansion of the Edition 1 categories where the additional categories were informed by Murray's 'need' and 'press' categories (Luborsky, 1998b) and were structured around the three components (35 Wishes, 30 Responses from Other and 20 Responses of Self); and the Edition 3, Reduction of Edition 2 into eight clusters for each component (Luborsky, 1998b). These standard category editions were derived through statistical processes (Crits-Christoph, 1998). As the Standard Categories are not used in this study, the reader is referred Luborsky's (1998b) chapter on the use of the

CCRT method as well as to Barber et al.'s (1998) chapter on the CCRT standard categories. The Standard Categories allow for reliable comparisons to be made between patients and CCRT changes can be assessed across phases of therapy (Barber et al., 1998).

Reliability

Investigations of reliability have been summarised by Luborsky and Diguer in terms of the level of agreement of judge's identification of relationship episodes and the agreement of independent judges on CCRT scoring (1998). The reliability of scoring the CCRT shows high agreement according to the percentage agreement method (Luborsky & Diguer, 1998). However, the reliability of scoring the CCRT using the weighted kappa is more precise. This is because the kappa calculation determines the proportion of agreement after chance agreement is removed (Luborsky & Diguer, 1998). Luborsky and Diguer explain how sometimes it is appropriate to weight the agreement to make it more precise. For instance, some disagreements are less important than others and can be ascribed a value ranging between 1.0 (perfect agreement), that is, when both judges listed the identical wish [W], response from other [RO] or response of self [RS] as the most frequent across ten relationship episodes [RE] (Luborsky & Diguer, 1998). Lower weights of .66 and .33 were respectively assigned to the second and third highest frequency of the same components of each CCRT judge (Luborsky & Diguer, 1998).

In spite of assured reliability, Crits-Christoph, Demorest, Muenz and Baranackie (1994) identify a number of limitations associated with the CCRT method of adhering to the tailor-made process followed by the coding into standard categories. Their first criticism is directed at the coding of the W, RO and RS in terms of presence/absence.

They suggest this restricts the ability to discern the similarity of relationship themes across RE's and will consequently underestimate the extent of pervasiveness (Crits-Christoph et al., 1994). Their second concern pertains to how the CCRT appears to assume thematic connections between the different components [W, RO and RS]. This assumption has been challenged and the authors propose that RO's are scored only when they relate to the W and the RS (Crits-Christoph et al., 1994). The third limitation is attributed to a risk of interpreter bias that is created by the judges reading of the entire transcript and sometimes even changing scores based on subsequent re-reading. It is thought that such procedures may over estimate the pervasiveness (Crits-Christoph et al., 1994; Connolly et al., 2000). In response to these criticisms, an alternative method was developed, the Qualitative Assessment of Interpersonal Themes [QUAINT] (Crits-Christoph et al., 1990). Additional criticisms have been directed at the reliability of the standard categories and framed the justification to reformulate the coding system (Albani et al., 2002). The new category system, the Core Conflictual Relationship Theme – Leipzig/Ulm, was chosen to compare to the QUAINT given its reported advantages over the older coding system (Albani et al., 2002). Both methods will be discussed in subsequent sections.

1.2.3 Valence

Clinicians have been in the habit of ascribing positive versus negative transference to patient narratives; a practice that has been incorporated into the CCRT method (Grenyer & Luborsky, 1998; Albani, Benninghofen et al., 1999). Within the CCRT context, an appraisal of positive means the patient has described non-interference or an expectation of non-interference with the satisfaction of the wish. Conversely, a negative appraisal suggests that the patient has narrated an experience or expectation of

interference with the satisfaction of the Wish (Grenyer & Luborsky, 1998). The original two-category system (i.e., positive - negative) of rating response from other (RO) and response of self (RS) has expanded to four categories in order to incorporate the degree of positivity and negativity. The mapping positive and negative components over the duration of psychotherapy can illustrate the pattern of the therapeutic process which may be related to psychotherapy outcomes (Grenyer & Luborsky, 1998). For example, Grenyer and Luborsky found clinical changes across therapy related to changes in the response of self component, whilst the response from other component showed little variation across therapy (1998). The valence dimension of the CCRT system was further substantiated by Albani et al.'s (1999) investigation into the relationship between the valence on the RO and RS components and the severity of the psychological disturbance. These authors assert their results are commensurate with observations in the clinical arena of psychoanalysis; that "psychic disorders develop out of an interpersonal context and are evident there" (Albani et al., 1999, p.463).

1.2.4 Quantitative Assessment of Interpersonal Themes Method

The Quantitative Assessment of Interpersonal Themes (QUAINT) method draws on theoretical constructs and methodological process of Luborsky's CCRT methods and Benjamin's Structural Analysis of Social Behaviour [SASB] (Baranackie & Crits-Christoph, 1992; Crits-Christoph, 1998). The QUAINT method is an adaptation of the CCRT method. Specifically, it has adopted the key structural components of the CCRT method as well as some procedural elements. Therefore, like the CCRT method, the QUAINT method identifies the relationship episode within the therapy transcript and scores the W, RO and RS components. Each RE is also appraised for completeness of the interpersonal interaction and the richness of detail (Baranackie & Crits-Christoph,

1992). Unlike the CCRT method, the QUAINT method employs an independent judge to extract each relationship episode from the entire transcript, code the individual RE and place it in a random order. The collection of the RE's are passed onto judges to perform the scoring. The QUAINT scoring system relies on a standard list of items for each of the categories of W, RO and RS. This standard list was derived from the three circumplexes that make up the cluster model of the Structural Analysis of Social Behaviour [SASB] model (Baranackie & Crits-Christoph, 1992). The judges rate the extent to which each item in the list for each component is present on a 1- to 5-scale: 1 = not present, 3 = moderately present and 5 = strongly present (Baranackie & Crits-Christoph 1992). Once the QUAINT ratings are completed the data is subject to various statistical analyses, depending on the research question. Investigations relating to pervasiveness of relationship themes may include calculating inter-judge reliability or comparing profiles of themes across different relationship episodes. The main strength of the QUAINT method is its ability to eliminate the potential rater bias that is created when narratives are rated in context of the entire transcribed psychotherapy session (Connolly et al., 2000).

The key weakness of the QUAINT method conflicts with its predominant strength; that is, the empirical sophistication detracts from the sensitivity of the clinical phenomenon. This is a delicate concern given the determination to ensure that the measure maintains a clinical sensitivity. Previous uses of the QUAINT method noted limitations in the design that compromise the confidence in the conclusions drawn from the results. For example, Crits-Christoph et al. (1990) noted weaknesses in their reliability results and suggested a larger sample was required.

1.2.5 The Core Conflictual Relationship Theme-Leipzig/Ulm Method

The Core Conflictual Relationship Theme-Leipzig/Ulm or 'logically unified' [CCRT-LU], the most recent CCRT methodological development, was formulated by a group of German researchers who had noted limitations in their use of the German version of the standard category and cluster systems (Albani et al., 2002). In particular, lower reliabilities in their CCRT studies had been observed which they attributed to different evaluation procedures for kappa than those used in the American studies (Albani et al., 2002). Alternatively, they suggest the differences may be due to variances in scoring procedures: the German studies are based on naturalistic clinical design, rather than a reliance on relationship episodes (Albani et al., 2002). Albani et al. assert the underlying construct of the category system accounts for the lower reliability statistics (2002). The CCRT-LU category system was formulated through an extensive process of reviewing existing category systems, evaluating CCRT data and collating responses to a CCRT user questionnaire (Albani et al., 2002). Furthermore, principles of predicate calculus were incorporated into the CCRT-LU model to frame the patients' expression within the category system (Albani et al., 2002).

Table 1 Dimensions of the CCRT-LU Category System

W				R			
WO		**WS**		**RO**		**RS**	
"The other should (…)."		"I want to (…)."		"The other does (…)."		"I do (…)."	
WOO	WOS	WSO	WSS	ROO	ROS	RSO	RSS
"The other should (…) to him/herself or other."	"The other should (…) to me."	"I want to do (…) to the other."	"I want to do (…) to me."	"The other does (…) to him/herself or other."	"The other does (…) to me."	"I do (…) to the other."	"I do (…) to me."

Note: W = wishes; R = responses; O = other; S = Self
(Albani et al. 2002, p.327)

The CCRT-LU method is characterised by a three-tier hierarchical category system and a structure of object-directed and subject-directed wish, 'response of other' and 'response of self' components. The high-level consists of 13 cluster categories. Within each of these 13 clusters, 2-5 divisions are made per cluster producing the mid-level 30 categories. The 119 low-level sub-categories are similarly formed from a content division of the mid-level 30 categories. The classification of object- and subject-directed components (See Table 1) produce four key components [WO, WS, RO and RS] that can then be divided into eight sub-dimensions [WOO, WOS, WSO, WSS, ROO, ROS, RSO and RSS] (Albani et al., 2002). Because the wishes, responses of other and responses of self are analogous they are scored from the hierarchical category structure (Albani et al., 2002) therefore doing away with the need for individual item lists per component (as is the case for the QUAINT and Standard Category methods).

The CCRT-LU system is also structured around the Harmonious and Disharmonious dimensions which parallel Dahl's attraction-repulsion (positive-negative) dimension (Albani et al., 2002). The CCRT-LU's Harmonious and Disharmonious dimensions are intended to detract from the positive and negative valence on the response of other and response of self (Albani et al., 2002). Instead, the reference to Dahl's theory of emotion facilitates the an understanding of the direction of

emotion (Albani et al., 2002). Dahl's classification of emotions is comprised of three dimensions: Orientation [IT-ME], Valence [ATTRACTION-REPULSION / POSITIVE-NEGATIVE] and Activity [ACTIVE-PASSIVE] (Dahl, Holzer & Berry, 1992). Together these dimensions form a classification tree which can be read to explain the functional relationship between these dimensions of the emotions (Dahl et al., 1992).

The CCRT-LU system was trialled on a sample of 32 patients' clinical interviews and compared to the findings from the CCRT scores on the same data set (Albani et al., 2002). The CCRT-LU system demonstrated greater reliability coefficients for each component [CCRT-LU high-level clusters (13) W= .66, RO= .58 and RS=.63; and, mid-level categories (30) W= .60, RO= .58 and RS=.56] than the CCRT method [CCRT clusters: W= .48, RO= .47 and RS= .65; and, standard categories: W= .42, RO= .37 and RS= .52] (Albani et al., 2002). Moreover, the distribution of the CCRT-LU categories suggests this system allows for more specificity of interpersonal themes than the CCRT method (Albani et al., 2002). The authors concluded the CCRT-LU is more effective at differentiating individual's primary relational patterns (Albani et al., 2002). The CCRT-LU method has also been applied to a single case for the purpose of investigating therapeutic processes in a course of psychoanalytic therapy, according to the Ulm Process Model (Albani et al., 2003). From 517 sessions, systematic sampling produced a data-set of 92 sessions from which at least 10 RE's per session were identified (Albani et al., 2003). The CCRT pattern, based on absolute frequencies, for the entire therapy was: WO - *"others should be attentive to me"*; WS - *"I want to be self determined"*; RO - *"others are unreliable"*; and, RS - *"I am dissatisfied, scared"* (Albani et al., 2003). The findings from this study

conferred with clinical assessment of the case that the therapy was successful (Albani et al., 2003). The CCRT-LU system revealed the patients' subject-directed wishes and responses demonstrated "the patient was able to expand her freedom of action and acquire new competencies, and that her depressive symptoms decreased" (Albani et al. 2003, p.28). Through this case study, the CCRT-LU method demonstrated its ability to reveal aspects of the interpersonal phenomenon that parallels the transference concept (Albani et al., 2003).

These two investigations into the application of the CCRT-LU method highlight its strengths as being a system that is both easy to learn and implement and is adept at identifying structural aspects of clinical transference (Albani et al., 2002; Albani et al., 2003). The CCRT-LU system, like the tailor-made process is conducive to clinical settings in the process of structuring and monitoring clinical material (Albani et al., 2003). In spite of the method's sensitivities to clinical material, it does not seek to capture unconscious process or appraise defense mechanisms although these would form part of the clinical material studied (Albani et al., 2003).

1.2.6 Mastery as a process and outcome variable

Mastery has been offered as a psychological construct that is capable of sensitising both a change process and an outcome index in psychotherapy (Grenyer, 2002). Grenyer commenced his investigation of mastery with the proposal "that compared with individuals with a low level of mastery, those with a high level of mastery have a greater sense of adaptive control over their emotional reactions when faced with conflicts in interpersonal relationships and are better able to understand the origins and motives behind these conflicts" (2002, p.4). These principles formed the basis of the Mastery Scale, which appraises the individual's capacity for insight and

agency. Considering the CCRT methodology's mapping of the transferential relationship pattern parallels the Mastery Scale's evaluation of the extent to which the patient has mastered interpersonal problems, it is sensible to employ these complementary systems. Furthermore, these comparable methodologies have the added advantage of sharing a basis in psychodynamic theory. The reliability and validity of the Mastery Scale has been demonstrated as exemplified by Grenyer's finding that significant correlations were established between changes in mastery and changes in clinical outcome scores, such as the HSRS (r = .54) (2002).

1.3 Aims of the Study

The present study intends to contribute to the general body of psychoanalytic research and the specific domain of CCRT research. The CCRT methodologies have predominantly been applied to samples of brief psychotherapies, such as Supportive Expressive Psychodynamic Psychotherapy (Connolly, Crits-Christoph et al. 2000), psychodynamic psychotherapy (Crits-Christoph, Cooper & Cooper, 1988) or Cognitive-Behavioural Therapy (Connolly et al. 1996). One other study has applied the CCRT-LU system to a single case of psychoanalytic treatment (Albani et al. 2003).

This study stands out as the first application of CCRT methods to a moderate-sized sample of psychoanalytic therapy. Furthermore, for the first time two CCRT systems are compared allowing new methods to be determined for the comparison of CCRT patterns derived from different scoring systems, the QUAINT and the CCRT-LU. The findings will also contribute to the collection of data on the characteristics and qualities of the differing methodologies, such as the multiplicity or singularity of interpersonal relational themes.

Study 1: A comparison of the QUAINT and CCRT-LU Methodological Systems

This study presented in chapter 2, aims to compare and contrast two related CCRT methodologies: the QUAINT and the CCRT-LU systems. It is hypothesised the CCRT systems will reflect similar interpersonal relationship patterns characteristic of the respective CCRT methods. The investigation sought to first determine how each of the related CCRT methodologies captures the relational patterns described by patients through their narratives of interpersonal interactions. Specific research questions, to be addressed in chapter 2, include:

1. What are the characteristics of the relational patterns produced by each of the three CCRT methods (tailor-made, QUAINT & CCRT-LU)?
2. How do the QUAINT and the CCRT-LU compare?

Study 2: An investigation of changes in CCRT patterns and their relationship to clinical measures

This study, to be presented in chapter 3, aims to examine the relational patterns of patients receiving long-term psychoanalysis and to investigate the changes of these patterns, in particular, the extent to which the patterns are modifiable. The specific hypotheses include: (1) The 'response of other' [RO] and the 'response of self' [RS] components of the CCRT formulation will become more harmonious across the course of therapy, as indicated by a shift in the distribution of themes from the Disharmonious dimension into the Harmonious dimension of categories; (2) interpersonal relationship themes will become more pervasive, as indicated by an increase in the number of endorsed categories on the RO and RS components; and, (3) patient's freedom to act will increase as indicated by an increase in valence ratings on the RS component. The following research questions were posed to guide the subsequent investigation into the

relational pattern obtained through the application of a CCRT methodology.

1. To what extent are CCRT patterns modifiable?

2. What are the CCRT patterns of patients receiving long-term psychoanalysis?

3. How do these results relate to Mastery, GAF and Improvement?

Chapter 2

Study 1: A Comparison of the QUAINT and CCRT-LU Methodological Systems

2.1 METHOD

2.1.1 Participants

The participant's had been patients of seventeen psychoanalysts who had participated in the Analytic Research Group of the Institute of the Pennsylvania Hospital or from similar psychoanalytic research initiatives in other locations (Luborsky, Stuart et al., 2001). These cases came to form the Penn Psychoanalytic Treatment Collection as an archival data set consisting of patient's complete and recorded psychoanalytic treatments. This data set is immediately amenable to psychoanalytic process research as it satisfies five essential criteria: (1) each case was tape-recorded with the understanding it would be used for research purposes once the treatment was terminated; (2) every therapy session from each case was available; (3) standard treatment outcome measures were applied to all cases; (4) independent clinical evaluators provided quantitative and qualitative judgements of selected transcribed sessions; and, (5) the collection is a moderately sized sample suitable to analyses (Luborsky et al., 2001).

The seventeen patients were aged between 22- and 65-years. Eleven of these patients were female; of whom six were married with children and five had never been married but did speak of their past or current close relationships. Of the six male patients two were married however one became divorced during the period of his therapy and four had never married however each spoke of past or current close

Table 2 Demographic Characteristics of Patients: Age, Gender and Personality Disorder Features

NAME^	AGE	GENDER	PERSONALITY DISORDER FEATURES	KERNBERG'S NEUROTIC vs. BORDERLINE TYPOLOGY
Quin	29	Female	Dependent	Neurotic
Gerta	35	Female	Avoidant	Neurotic
Sally	25	Female	Avoidant	Neurotic
Artie	65	Male	Obsess-Compuls	Neurotic
Quoit	31	Female	Dependent	Neurotic
Carla	38	Female	Avoidant	Neurotic
Amal	52	Female	Dependent	Neurotic
Troy	22	Male	Obsess-Compuls	Neurotic
Karen	34	Female	Dependent	Neurotic
Ken	32	Male	Obsess-Compuls	Neurotic
Kim	33	Male	Antisocial	Borderline
Leah	28	Female	Borderline	Borderline
Tara	30	Female	Borderline	Borderline
Wyn	45	Female	Dependent	Neurotic
Victor	34	Male	Paranoid	Borderline
Sue	31	Female	Paranoid	Borderline
Kris	32	Male	Borderline	Borderline

^All names are pseudonyms.

relationships. In a previous study, two experienced clinicians appraised each patient's set of transcribed psychoanalytic treatment for descriptive features of personality disorders (Martin, 2003). Their process was guided by the descriptors and diagnostic criteria for personality disorders contained in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (4th Ed., DSM IV, American Psychiatric Association, 1994) and was conducted in lieu of formal diagnostic procedures, as this was archival data (Martin, 2003). The patients were ascribed various subtypes of features of personality disorders and were categorised into either two groups of severity based on Kernberg's personality disorder model (Kernberg, 1984): group 1 the neurotic personality organisation characterised by less severe infusion of mental life with aggression; and, group 2 the borderline personality organisation characterised by more severe infusion of mental life with aggression. Table 2 lists the demographics of this sample.

2.1.2 Psychoanalysis

The psychoanalytic treatment was conducted by highly experienced analysts, each with a minimum of eight years in psychoanalytical practice (Luborsky et al., 2001). The duration of psychoanalysis ranged from 1 to 6 years with the patients attending multiple sessions per week. The data set for the current study consisted of specific sessions drawn from the early, middle and late phases of therapy of each patient's treatment. In total there were 137 therapy sessions transcribed, with an average of 8 sessions per patient available. Thirteen patients had sessions from early, middle and late stages of therapy. The remaining 4 patients had early and late therapy sessions only. The number of sessions per phase of therapy ranged between 2 to 6 in the early phase with an average of 2.9 sessions per patient/early phase; between 1 and 3 in the

mid phase, with an average of 2.1 sessions per patient/mid phase; and, a range between 2 and 5 sessions per patient within the late phase of treatment, with a average of 3.6 sessions per patient within the late phase (Table 4 on p.37 provides a summary on the distribution of sessions within the data set).

2.1.3 Data Set

To derive therapeutic material for CCRT analysis, an independent judge read the transcripts and identified the patients' narratives of interpersonal interactions; that is, the relationship episodes (RE's) are the unit of analysis (Luborsky, 1998b). In accordance with Luborsky's method each RE requires a completeness rating of at least 2.5 out of 5 to be eligible for analysis, whereby a complete narrative as a clear beginning, middle and end (Luborsky, 1998a). Luborsky and Diguer have reported on the satisfactory reliabilities of three aspects of relationship episodes: the location within the transcript, the completeness of the RE and the object, or other of the RE (1998). On average there are four complete RE's per session, with an approximate range of one to seven; the length of narratives based on the number of typed lines within a transcript, averages 51.1 lines (the range is 7-207 lines); and the three main other people in the RE are the therapist, a family member and an intimate relation (Luborsky, Barber, Schaffler & Cacciola, 1998).

2.1.4 Measures

Tailor-Made CCRT

As several aspects of the tailor-made system have been retained in the different methodological developments, such as the QUAINT and the CCRT-LU systems, a description of this method is warranted. Specifically, this study followed Steps 1, 2, 1' and 2' of Luborsky's tailor-made system (1998b), including the application of valence

ratings, as a precursor to scoring with the CCRT-LU system. The individual relationship episodes [RE's] are scored within the transcript of the session. Hence the RE's are appraised in a temporal sequence, and therefore within the therapeutic context. Within the transcript the judge marks those thought units expressed in the RE text, that reflect the quality of each component - the wish, need or intention [W]; the response of other(s) [RO] as perceived by the patient; and the responses of the self [RS] (Luborsky, 1998b). Within a single RE several thought units per component may be evident (Luborsky, 1998b); this is most likely to be encountered when the RE has a high completeness rating and is of greater length. Only one theme, the most frequent, per component was used as a final score or CCRT pattern for each RE. Luborsky explains "the measure of the CCRT rests on the pervasiveness of each type of component *across* narratives, not *within* narratives" (Luborsky, 1998b, p.25). Therefore, a calculation of the most frequently occurring theme for each component is selected to formulate the CCRT pattern for each phase of therapy (Luborsky, 1998b), per patient. For example, a RE may consist of thirteen thought units which are assigned to one of the three components, W, RO and RS, producing, for example seven thought units scored as RO's and four as RS and two as the W. Based on the highest frequency principle, a single theme is selected for each component: for example, W-*to be in control*, RO-*is intrusive* and RS-*feels uncomfortable*. This is repeated for each RE and followed by a process of identifying a single theme per component for each phase of therapy based on the highest frequency of themes. Luborsky's (1998b) chapter on the use of the CCRT method provided additional instruction, such as the making of inferences on the wish component, to ensure the method was appropriately applied. The crucial difference between the tailor-made and coding systems (e.g. CCRT-LU) is that the patients own

words are used to formulate the CCRT components (in the tailor-made method), rather than abstracting these to standard categories (in the CCRT-LU system).

Scoring with the QUAINT Method

The QUAINT method was the first CCRT system to be applied to the data, as to do otherwise would violate the empirical conditions of the QUAINT measure. This system, including the procedures for training judges, was employed in accordance with Baranackie and Crits-Christoph's (1992) method. The QUAINT system stipulates the judge is blind to the identity of the patient and the characteristics of their respective analysis. Therefore, an independent judge prepares the data by extracting the identified RE's from the therapy transcripts, ensuring all indicators of patient characteristics and therapy markers, such as session numbers and dates, have been removed. These RE's are coded, placed in random order and provided to judges who work independently of one another. The judge reads a RE and then rates the content against the individual QUAINT items.

Once scored, cluster analyses were conducted within the three phases of therapy [beginning, middle and late] to reveal relationship themes for each patient. Following the method employed by Connolly et al. (1996), a nonoverlapping agglomerative hierarchical cluster analysis (SPSS/PC, 11.0), using the method of average linkage was used, along with the Pearson Correlation Coefficient as a similarity index. This procedure is considered to be most accurate in evidencing the true structure in cases (Connolly et al., 1996). A correlation coefficient of at least 0.3 was used to indicate sufficient similarity amongst themes (Connolly et al., 1996). The SPSS syntax is in Appendix C.

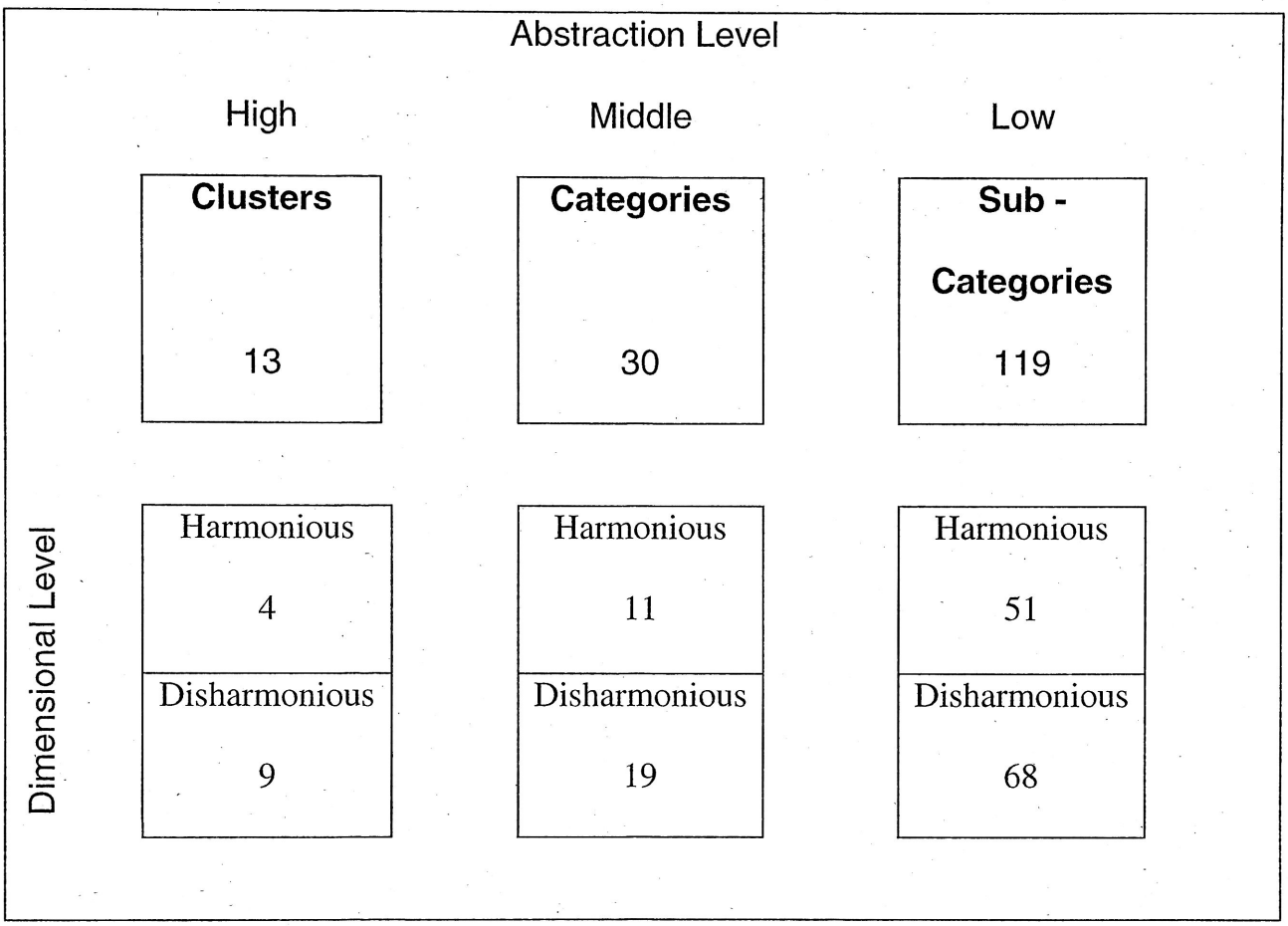
The QUAINT method elicits several clusters of relational themes (profile analysis), within each phase of therapy, per patient. However, because the CCRT has an emphasis on a central relationship pattern which is evident from the patient's most frequent theme (Luborsky, 1998a), and in order to contrast the relational patterns captured by the QUAINT and the CCRT-LU methods, the output of each system was reduced to a single theme per component within each phase of therapy, per patient. Therefore, to prepare the QUAINT data for comparison to the CCRT-LU data, a single CCRT formulation per phase of therapy was determined by selecting the cluster with a median correlation coefficient between 0.3 and 1.00. In the rare (less than 5%) event the same correlation coefficient represented several themes, the cluster reflecting the least amount of conflict, or was most homogeneous in theme, was chosen. There is no published data on how previous researchers have resolved this dilemma. Therefore, we chose this conservative rule. This selection process was repeated to produce a 'primary' CCRT formulation per patient and per phase of therapy.

Scoring with the CCRT-LU Method

The reformulation of Luborsky's tailor-made and category systems, the Core Conflictual Relationship Theme-Leipzig/Ulm (CCRT-LU), has a hierarchical structure and permits a classification of object- and subject-directed wishes and responses (Albani et al., 2002). The judge first relates the patient's speech to one of the 13 (high-level) clusters; followed by a translation to one of the 30 (second-level) categories; and lastly, the patients' speech is related to a (low-level) subcategory (Albani et al., 2002). Within each second-level category there are two to five categories to choose from; and similarly, within each low level subcategory there are two to eight categories to select from (Albani et al., 2002). [See Table 3 for a description of the levels of CCRT-LU

categories and refer to Appendix B for the CCRT-LU hierarchical category system.] In addition to the assigning of categories to the patients expression, the judge also specifies the subject- object-direction [WOO, WOS, WSO, WSS, ROO, ROS, RSO and RSS].

Table 3 Description of the hierarchical structure of the CCRT-LU system.



The methodological structure of the CCRT-LU system allows for flexibility in assigning categories as the predicates are not meant to be read literally, but instead as an interpretation or translation derived through a process of reflecting on the clients speech and circumstance (Albani et al., 2002). For example, Albani et al. (2002) describe how in one context 'being calm and patient' can be viewed as a weakness; and yet in a different context it may be regarded as a strength. This may also be related to Luborsky's instruction on the moderate use of inference through the use of the "wet,

gray software, the cortex of a human judge...a tool not likely to be supplanted by the dry, any color hardware or any style software of the computer" (1998b, p.25).

As mentioned previously, because the CCRT has an emphasis on a central relationship pattern, which is evident from the patient's most frequent theme (Luborsky, 1998a) the output of each system was reduced to a single theme per component within each phase of therapy, per patient. The following section explains the procedure of modifying the scored CCRT-LU data to make the data comparable with the QUAINT data.

The data, in its naturalistic form (i.e. sessions arranged per patient and in temporal sequence from early to late therapy), was scored in accordance with the tailor-made method and then coded using the CCRT-LU categories. For the purpose of comparing CCRT methodologies three components, i.e. the W, RO and RS, were identified within each RE. The CCRT-LU data selected for comparison with the QUAINT data was derived from the frequency distribution of the CCRT-LU mid-level categories for each phase of therapy [beginning, middle and late] for each patient. The most frequently occurring mid-level CCRT-LU category per component was chosen to formulate a CCRT per phase of therapy, per patient. In the event of an equal dispersion of categories or some other ambiguous distribution of categories (26% of total components), items were selected on the basis of the most frequent at the cluster level and/or the median item within the dimension [harmonious/disharmonious] with the highest occurring items. This selection rule adhered to the same conservative guideline used to select the ambiguous QUAINT clusters (see page 31).

2.1.5 Data Analysis and Statistical Inferences

Comparison of the QUAINT and CCRT-LU Methods

To facilitate the comparison of methodologies, the derived QUAINT CCRT formulations were translated into the CCRT -LU category system. The necessity to convert one coding method to the other enabled the direct comparison of the two coding systems. For the purpose of the methodological comparison, the choice to translate the QUAINT items into the CCRT-LU, rather than the other way around, was for practical reasons. It is difficult to re-formulate an existing CCRT-LU CCRT into a QUAINT CCRT, because the QUAINT uses a rating scale scored on the whole relationship episode. Conversely, it is easy to convert an existing QUAINT CCRT because the components can be translated into the CCRT-LU category system. It was therefore sensible to convert QUAINT CCRT into the CCRT-LU categories, rather than attempt to do the reverse, which would probably be invalid.

To compare the QUAINT and the CCRT-LU systems the results of the QUAINT and CCRT-LU formulations per phase of therapy, per patient were then subjected to analysis using the method of the weighted kappa (Cohen, 1968). The weighted kappa calculates a "proportion of weighted agreement corrected for chance ... when different kinds of disagreement are to be differently weighted in the agreement index"(Cohen, 1968, p.215). In this study the weighted kappa was calculated by a priori application of weights to four criteria: a weight of 0 indicated total agreement, a weight of 1 stated agreement at the dimensional (Harmonious vs. Disharmonious) level, a weight of 2 indicated agreement at the cluster level and 3 weighted agreement at the category level. The application of zero as indicative of total agreement may appear counterintuitive; nevertheless Cohen asserts zero as a reference to perfect agreement,

that is, no disagreement (Cohen, 1968). For ease of calculation and in accordance with Cohen's (1968) method these agreement weights were converted, with no effect on the statistical product, to disagreement weights. Cohen emphasises regardless of the choice of agreement or disagreement, the kw is a "chance-corrected proportion of weighted agreement" (1968, p.215). Landis and Koch (1977) have offered benchmarks with which to discuss kw values:0 to .40 suggests poor-fair agreement, .41 to .80 moderate-substantial agreement and .81 to 1.0 as almost perfect agreement. Several other studies have utilised these labels (e.g. Luborsky, Diguer, Andrusyna et al., 2004). Significance values are reported as sigma values which are interpreted as the higher the value the greater the confidence in the agreement index (Cohen, 1968).

Similarity Rating Method

Similarity ratings were scored by having judges compare the derived QUAINT CCRT with the tailor-made CCRT from the early stage of therapy. In the same way, the CCRT-LU was compared with the tailor-made CCRT. Two independent judges rated the degree of similarity on a 0 to 100 rating scale, where '0' specified no similarity, '50' indicated moderate similarity and '100' rated exactness. The mean ratings of the two judges were subjected to a paired t-test to ascertain the degree of similarity between the two methods with respect to the tailor-made or 'gold standard' CCRT. Finally, the QUAINT and the CCRT-LU were subjected to similarity ratings by two judges, producing an average similarity score for each component [W, RO & RS].

Statistical Inference

For all analyses criterion for statistical significance was p .05, unless otherwise specified.

2.2 RESULTS

Research Aim

To investigate two related CCRT methodologies: the QUAINT and CCRT-LU systems.

Hypothesis

The QUAINT and the CCRT-LU will generate similar CCRT relational patterns.

2.2.1 Description of Relationship Episodes and Inter-rater Reliability

Data set

The sample in this study consisted of four hundred and fifty-two (452) relationship episodes. The distribution pattern presented in Table 4, illustrates a trend of a greater number of RE's were derived from fewer sessions in the early phase of therapy whilst in the late stage of therapy more sessions are required to gain adequate numbers of RE's. Luborsky recommends (1998b), and it is the practice of CCRT researchers (e.g. Connolly et al., 1996; Crits-Christoph & Luborsky, 1998), to use the necessary number of sessions to obtain a minimum of 10 RE's. The median number of RE's for the early and late stages of therapy complied with this recommendation; however the number of RE's from the middle phase of therapy did not meet this benchmark.

Table 4 Distribution of transcribed & analysed therapy sessions & relationship episodes derived from the transcripts

		EARLY	MIDDLE	LATE	ALL
		N = 17	N = 13	N = 17	**N = 17**
SESSIONS	Number [in total]	50	26	61	**137**
	Median, [per patient]	3	2	3	**9**
	Range	2-6	0-3	2-5	**4-13**
RE's	Number [in total]	223	67	162	**452**
	Median, [per patient]	11	5	10	**30**
	Range	3-27	1-10	2-19	**5-46**

Table 5 gives a percentage description of the distribution of objects across the 452 RE's. This distribution is commensurate with Luborsky's suggestion most relationship episodes are about relationships with parents, spouses, friends and bosses (Luborsky, 1998b). Both current and past 'therapists' were counted under the Therapist category and is inclusive of both therapist narratives and enactments (Luborsky, 1998b). Step-parents were included under the 'Parent' category; current and past lovers were counted as 'Lovers'; and bosses, colleagues, friends, and other non-related persons were included within the 'Other' category.

Table 5 Distribution of object of RE across all patients

OBJECT	RE's (N = 452) %
Therapist	12
Parent(s)	22
Other family	8
Lover	29
Other	29

QUAINT inter-rater reliability

The one hundred and four (104) QUAINT items are divided across the three components: the Wish has 32 items; the Response of Other has 32 items; and the Response of Self has 40 items. A scale of 1 to 5 serves to rate the degree to which an item is evident in the RE, where "1" represents "not present" and "5" indicates "strongly present" (Baranackie & Crits-Christoph, 1992) [See Appendix A for a copy of the score sheets]. Judge A [LP] scored the entire set of 452 RE's. Judge B [JS] scored 101 (22%) of the 452 RE's. There was high inter-rater reliability based on the average agreement between the Judge A and Judge B. The intraclass correlation coefficients for each component was W: 0.77; RO: 0.84; and, RS: 0.67. Given the acceptable reliability of the judges, all the data from judge one was used for the main analysis.

CCRT-LU inter-rater reliability

The inter-rater reliability, on the CCRT-LU system, using a weighted kappa (kw), was high. Judge C [BG] scored approximately 5% of the total data set using the CCRT-LU method giving an inter-rater reliability of kw = 0.67 (z = 16.51). Reliabilities on each component also indicate fair-to-excellent agreement: Wish kw = .82 (z = 14.94), Response of Other kw = .85 (z = 15.72) and Response of Self kw = .91

(17.28). These findings are commensurate with other observations of the Wish component producing lower agreements than the RO and RS components (Luborsky & Diguer, 1998).

Similarity inter-rater reliability

Two judges rated on a 0 – 100 scale the similarity between the tailor-made CCRT and the QUAINT and CCRT-LU respectively. The inter-rater reliability between two judges on the QUAINT components produced an average intraclass coefficient of .92. Inter-judge agreement on the CCRT-LU components averaged .87. The ratings were applied to the CCRT formulations derived from the previously mentioned selection procedure of each CCRT system, for each patient and on each component (see Appendix D for the score sheets). That is, the tailor-made system (Table 6) was compared to the QUAINT method (Table 9) and then again the tailor-made (Table 6) was compared to the CCRT-LU system (Table 11). The inter-rater reliability of two judges' averaged ratings of similarity between the QUAINT and the CCRT-LU system, for each component gave intraclass coefficients of: W: .83; RO: .88; and, RS: .85.

2.2.2 Research Question 1: What are the characteristics of the relational patterns produced by each of the three CCRT methods?

Core Conflictual Relationship Theme-Tailor-Made Method

In the initial steps of scoring the tailor-made method the judge keeps close to the patient's words, or thought units. Several themes for each component, particularly the RO and RS are identified within each RE. Subsequent steps in the method calculate a primary, secondary and possibly a tertiary theme for each component within each RE

from the frequencies of themes. A single CCRT formulation (that is, the sequence of the W, RO and RS components) based on the highest frequency of themes represents the relational pattern for each phase of therapy. Table 6 provides a summary of the primary tailor-made CCRT's in the early therapy phase for each patient.

The CCRT scoring process guides the judges' interpretation of the patient's expressions. The resultant theme is already distant from the patients' exact expression due to the interaction with the judges' interpretation of the patient's narrative. The Wish themes expressed by the patients are consistent with the defining qualities of this component; that is, the themes refer to the patients' needs and/or intentions (Luborsky, 1998a, 1998b). Across the seventeen patients several distinct themes were evident. One patient had two themes representing their Wish: patient 'Karen' wished "To be equal and to be accepted". The RO and RS components were almost entirely negative in their thematic content which is similar to previous observations of themes from early therapy phases (Grenyer & Luborsky, 1998). One exception was the positive theme, "Are accomplished and sophisticated", on the early RO component for patient 'Kim'. Across the 17 patients, ten distinct themes were evident on the RO component and thirteen themes were identified across patients on the RS component. In several instances, two themes were required to convey the patient's response of self.

Table 6 Early phase of therapy tailor-made primary CCRT formulations for all patients

	EARLY PHASE OF THERAPY		
Patient	**WISH**	**RESPONSE OF OTHER**	**RESPONSE OF SELF**
1 Quin	To be treated respectfully.	Accuses of being ridiculous	I don't understand.
2 Gerta	To please ...	Gets mad & huffy, doesn't notice me	I mess things up.
3 Sally	To be independent.	Are against me	At a standstill & feels resentful.
4 Artie	To be close.	There is nobody there	Yearning. Afraid.
5 Quoit	To be free.	Argue.	I get furious.
6 Carla	To be cared for.	Is insensitive	Feels afraid & resentful.
7 Amal	To be self-confident.	Are judgemental	Feels weak & insecure.
8 Troy	To make a good impression.	Are restraining	Gets frustrated.
9 Karen	To be equal & to be accepted.	Is rejecting	I get enraged. Feel scared.
10 Ken	To be self-sufficient.	They don't understand.	Get upset.
11 Kim	To be like others. Not to be different.	Are accomplished & sophisticated.	Feels angry & helpless.
12 Leah	To be strong in a relationship.	Is emotionally controlling.	I don't know what to do. Am afraid.
13 Tara	To be free to express.	Is unlikeable. Rejects me.	I get fed-up. Withdraws.
14 Wyn	To be powerful	Is controlling & criticising	Is angry & afraid
15Victor	To influence the other.	Others disregard me.	Feels resentful & furious
16 Sue	To have security	Expose me & devalue me.	Feels worthless & humiliated.
17 Kris	To enjoy one another's company.	Aren't interested and are abusive.	Becomes antagonistic. Hurt. Angry.

The CCRT has been evaluated using a dynamically sensitive measure of change, the Mastery Scale. Unlike the traditional symptom judgements (e.g., the B.D.I.-II) the Mastery Scale was derived from psychodynamic theory and therefore is a more relevant measure than traditional atheoretical symptom based measures. In order to ensure structural changes measured by the CCRT are sensibly related to predicted psychodynamic changes, the Mastery Scale has been recommended as a tool to overcome the limitations of other measures. The same data set used in this study has been scored and analysed using the Mastery Scale (Martin, 2003). A calculation of residual change Mastery Scale scores [refer to Appendix E] was used to rank patient's improvement. Using these scores, five patients were selected to illustrate CCRT patterns across the stages of therapy. Table 7 lists the tailor-made primary CCRT

patterns of these five patients whose improvement through therapy have been ranked: Patient 'Artie' and patient 'Gerta' were rated as having improved, patient 'Karen' was considered to have demonstrated mixed improvement; and patients 'Sue' and 'Kim' were ranked as least-improved. The tailor-made themes usually translate with ease into a version of the standard categories (e.g. Barber, Crits-Christoph & Luborsky, 1998; Luborsky, 1998b). There are however, occasions when the judge may struggle to find the tailor-made theme represented in the standard category dictionaries (Luborsky, 1998c).

Table 7 Middle and end phase of therapy tailor-made primary CCRT formulations for two most-improved, one mixed-improved and two least-improved patients

	Patient		Middle Component & Tailor-Made Formulation		Late Component & Tailor-Made Formulation
Most Improved	2 Gerta	W	To play & have fun.	W	To give myself confidence.
		RO	Yells, screams & hollers.	RO	There is a positive atmosphere.
		RS	I get mixed up. I feel guilty.	RS	I will say what I feel.
	4 Artie	W		W	To be competent.
		RO	NO MIDDLE THERAPY SESSIONS	RO	Is supportive.
		RS		RS	I am happy. Felt joy.
Mixed Improved	9 Karen	W	To be equal. To have a choice.	W	To be equal.
		RO	Doesn't give permission. Feels superior.	RO	Oppose me.
				RS	Furious. Terrified.
		RS	Furious.		
Least Improved	11 Kim	W	To get things sorted out.	W	To protect self.
		RO	Are intolerant.	RO	Don't care.
		RS	Withdraws & feels furious.	RS	Withdraws.
	16 Sue	W	To be sure of myself.	W	To be liked.
		RO	Is generous.	RO	Are not interested.
		RS	Feels worthless.	RS	Fearful & self-accepting

The primary CCRT tailor-made formulations for Artie and Gerta clearly evidence a change in relational themes from early to end phase of therapy. Artie's early CCRT formulation (Table 6) captures his wish to be close, only for him to experience others ignoring him to which he reacts with feelings of fear. Near the completion of

therapy, Artie is relating his wish to be competent and reports others as being supportive, which leaves him with a sense of feeling good (Table 6). Similarly, Gerta's CCRT formulation mapped across the phases of therapy, comprised of a negative RO, 'is critical', and a RS, 'is afraid', in the early phase of therapy in response to a wish 'for approval' (Table 6). The negative valence on the RO and RS components was still evident in the middle phase of therapy even though their themes differed (Table 7). By the end phase of therapy, Gerta's CCRT formulation was suggestive of a satisfied Wish on both components: the RO is 'accepting', and the RS is 'expressive' (Table 7).

Quantitative Assessment of Interpersonal Themes [QUAINT]

The cluster analysis was performed on the individual components (W, RO, RS) for each patient and within the different stages of therapy (early, middle, end). Multiple relational themes, or QUAINT profiles, were evident from these cluster analyses. These relationship themes were derived from the assigning of a median interobject correlation of at least .30 to the nonoverlapping agglomerative hierarchical cluster analysis (Connolly et al., 1996). The correlation coefficient of .30 or greater establishes meaningful similarity among relational themes and avoids aberrant values (Connolly et al., 1996). The absolute frequencies of clusters, defined by a minimal coefficient of .30 are displayed in Table 8. Across the 141 components, 108 (77%) obtained clusters above .30 and less than 1.00; 9 (6%) components failed to produce any clustering of themes; 7 (5%) produced single clusters with 1.00 as the coefficient and 17 (12%) produced multiple clusters with 1.00 as the coefficient. Overall, these absolute frequencies are indicative of the QUAINT's capturing of multiple relational themes.

Table 8 Absolute frequency of QUAINT cluster themes with co-efficients greater than 0.3 and less than 1.00

	EARLY			MIDDLE			LATE		
Patient	**W**	**RO**	**RS**	**W**	**RO**	**RS**	**W**	**RO**	**RS**
1 Quin	1	3	4	1*	1*	2*	2	4	10
2 Gerta	2	2	3	0	0	0	3	3	4
3 Sally	2	2	2	1	1	2	3	1	4
4 Artie	2*	1	1	-	-	-	1	1*	5*
5 Quoit	1*	1	6	-	-	-	3	2	3
6 Carla	4	2	4	2	3	2	3	4	3
7 Amal	8	10	12	-	-	-	6	9	21
8 Troy	1	1	3	-	-	-	2*	9*	9*
9 Karen	8	8	13	5	7	11	7	8	9
10 Ken	1	10	4	1	1	3	2*	2*	1
11 Kim	2	2	11	2	1	4	3	1	5
12 Leah	4	4	9	1	1	2	1	2	3
13 Tara	3	4	7	0	0	0	2	2	6
14 Wyn	2	3	4	1*	0	4*	6	3	4
15Victor	3	4	4	5*	8*	9*	2	4	10
16 Sue	1	1	3	1*	1*	3*	0	0	4*
17 Kris	2	4	5	1	2*	3	2*	3*	1
TOTAL	47	62	95	21	26	45	48	58	102

- no middle sessions; * themes with coefficients = 1.00; 0 refers to no correlations

The comparison of the QUAINT data with the CCRT-LU data was framed around the selection of an individual cluster from each CCRT component for the individual patient and from each phase of therapy, including those with coefficients of 1.00. The rationale underpinning this procedural element relates to Luborsky's interest in the pervasiveness of relational themes across narratives, not necessarily within narratives (Luborsky, 1998b). Table 9 presents the selected QUAINT clusters for the early phase of therapy for all seventeen patients. This particular arrangement of the QUAINT data disguises the systems' capacity to elicit multiple themes. Nevertheless, a degree of multiplicity of relational patterns is evident (see Table 9) as is the QUAINT system's ability to reflect the patient's relational conflicts.

Table 9 Early phase of therapy 'primary' QUAINT formulations for all patients

Patient	EARLY PHASE OF THERAPY WISH	RESPONSE OF OTHER	RESPONSE OF SELF
1 Quin	To be trusting & relying [23] and To be walling off & distancing [31]	Is watching & controlling [5] and Is belittling & blaming [6]	Is ignoring & neglecting [8] and Is self-rejecting & destroying [38]
2 Gerta	Other to be affirming & understanding me [4] and To be disclosing & expressing [19]	Is nurturing & protecting [4] and Is ignoring & neglecting [8]	Is deferring & submitting [13] and Feels fear [30]
3 Sally	To be joyfully connecting [21] and Other to be joyfully connecting with me [22]	Is watching & controlling [5] and Feels interested [20]	Feels constrained & helpless [29] and Feels sad [32]
4 Artie	To be affirming & understanding [3] and Other to be nurturing & protecting me [8]	Is belittling & blaming [6] and Is ignoring & neglecting [8]	Feels powerful [21] and Feels constrained & helpless [29]
5 Quoit	To be joyfully connecting [21] and Other to be joyfully connecting with me [22]	Is affirming & understanding [2] and Feels hostile & angry [23]	Is attacking & rejecting [7] and Is self-monitoring & restraining [36]
6 Carla	To be asserting & separating [17] and To be protesting & recoiling [29]	Is sulking & scurrying [14] and Feels hostile & angry [23]	Is protesting & recoiling [15] and Feels hostile & angry [23]
7 Amal	To be attacking & rejecting [13] and To be asserting & separating [17]	Is ignoring & neglecting [8] and Is protesting & recoiling [15]	Is walling off & distancing [16] and Feels annoyed & irritated [22]
8 Troy	Other to be affirming & understanding me [4] and Other to be nurturing & protecting me [8]	Is disclosing & expressing[10] and Feels trusting & relying [18]	Is attacking & rejecting [7] and Feels constrained & helpless [29]
9 Karen	To be affirming & understanding [3] and To be loving & approaching [5]	Is ignoring & neglecting [8] and Is walling off & distancing [16]	Is asserting & separating [9] and Feels disgusted [31]
10 Ken	To be affirming & understanding [3] and To be trusting & relying [23]	Is freeing & forgetting [1] and Is ignoring & neglecting [8]	Is sulking & scurrying [14] and Feels disgusted [31]
11 Kim	To be loving & approaching [5] and To be joyfully connecting [21]	Is affirming & understanding [2] and Feels friendly [18]	Feels disgusted [31] and Is self-accepting & exploring [33]
12 Leah	Other to be affirming & understanding me [4] and To be asserting & separating [17]	Is watching & controlling [5] and Feels powerful [21]	Is deferring & submitting [13] and Feels constrained & helpless [29]
13 Tara	To be freeing & forgetting [1] and To be joyfully connecting [21]	Is walling off & distancing [16] and Feels hostile & angry [23]	Feels annoyed & irritated [22] and Is self-monitoring & restraining [36]
14 Wyn	To be disclosing & expressing [19] and Other to be disclosing & expressing me [20]	Is ignoring & neglecting [8] and Feels annoyed & irritated [22]	Feels constrained & helpless [29] and Is self-monitoring & restraining [36]
15Victor	Other to be affirming & understanding me [4] and Other to be nurturing & protecting me [8]	Is belittling & blaming [6] and Feels powerful [21]	Feels powerful [21] and Feels disgusted [31]
16 Sue	To be freeing & forgetting [1] and To be asserting & separating [17]	Is watching & controlling [5] and Is ignoring & neglecting [8]	Is self-disclosing & expressing [10] and Is self-indicting & oppressing & guilty [37]
17 Kris	To be nurturing & protecting [7] and To be disclosing & expressing [19]	Is attacking & rejecting [7] and Feels hostile & angry [23]	Is walling off & distancing [16] and Feels apathetic [24]

For example, Gerta's RS component in the early phase of therapy consists of two discordant items clustering with a correlation coefficient of .82. Similarly, in Quoit's first phase of therapy the RO contains items conflictual in thematic content. Across the seventeen patients, 15 Wish, 16 Response of Other and 20 Response of Self QUAINT items were represented within the various clusters.

Using the same sub-sample as that used to illustrate the CCRT tailor-made formulations, Table 9 and Table 10 lists the selected cluster items to represent the QUAINT formulations across the phases of therapy. In most instances, this particular constellation of QUAINT items reflect only a proportion of the entire content of the interpersonal narratives, as captured by the QUAINT system. Table 8 makes this explicit; for example, patients Gerta, Artie and Sue have only one or two clusters per component across all phases of therapy whereas Karen has several clusters for each component in each stage of therapy. Kim has 1-3 clusters for the majority of components across therapy, with multiple clusters on the early therapy RS component and several clusters on the middle phase RS component and the end phase W and RS components (see Table 8). The data presented in its current form does not exemplify findings from previous applications of QUAINT, such as the degree of repetitiveness of interpersonal themes (Crits-Christoph et al., 1994; Crits-Christoph, 1998). The only suggestion of such phenomenon is in the RO component across the middle and end stage of therapy for Karen and then in Kim's W component also in the middle and end phases of therapy.

Table 10 Middle and end phase of therapy 'primary' QUAINT formulations for two most-improved, one mixed-improved and two least-improved patients

	Patient		MIDDLE Component & QUAINT items		LATE Component & QUAINT items
Most Improved	4 Artie	W	NO MIDDLE THERAPY SESSIONS	W	01: To be freeing & forgetting. 05: To be loving & approaching.
		RO		RO	03: Is loving & approaching. 19: Feels loving.
		RS		RS	03: Is loving & approaching. 17: Feels permissive & freeing.
	2 Gerta	W	NO CORRELATIONS	W	25: To be deferring & submitting. 31: To be walling off & distancing.
		RO		RO	06: Is belittling & blaming. 07: Is attacking & rejecting.
		RS		RS	16: Is walling off & distancing. 22: Feels annoyed & irritated.
Mixed Improved	9 Karen	W	04: Other to be affirming & understanding me. 06: Other to be loving & approaching me.	W	02: Other to be freeing & forgetting me. 22: Other to be joyfully connecting with me.
		RO	07: Is attacking & rejecting. 15: Is protesting & recoiling.	RO	07: Is attacking & rejecting. 15: Is protesting & recoiling.
		RS	23: Feels hostile & angry. 37: Is self-indicting & oppressing & guilty.	RS	17: Feels permissive & freeing. 25: Feels liberated & independent.
Least Improved	16 Sue	W	04: Other to be affirming & understanding me. 20: Other to be disclosing & expressing me.	W RO	NO CORRELATIONS ON THE W & RO COMPONENTS
		RO	06: Is belittling & blaming. 21: Feels powerful.	RS	01: Is freeing & forgetting. 09: Is asserting & separating.
		RS	13: Is deferring & submitting. 29: Feels constrained & helpless.		
	11 Kim	W	09: To be watching & controlling. 13: To be attacking & rejecting.	W	03: To be affirming & understanding. 13: To be attacking & rejecting.
		RO	09: Is asserting & separating. 20: Feels interested.	RO	02: Is affirming & understanding. 17: Is permissive & freeing.
		RS	08: Is ignoring & neglecting. 23: Feels hostile & angry.	RS	15: Is protesting & recoiling. 22: Is annoyed & irritated.

Core Conflictual Relationship Theme-Leipzig-Ulm [CCRT-LU]

The CCRT-LU data was scored at the mid-level category (30 items) and the resultant CCRT-LU formulations were subjected to a selection process to facilitate the comparison with the related CCRT methodologies. Therefore, only the primary relational patterns are reported. Samples of interpersonal patterns from this procedure

appear in Table 11 as the relational patterns for all patients in the early phase of therapy. The CCRT-LU formulations in both Table 11 and Table 12 have had the WO and WS components collapsed into the single W component. Across the seventeen patients all Wish components were distributed within the Harmonious dimension and nine out of the possible eleven, themes were endorsed. The most frequently occurring Wish category was D2-'Being proud, Being autonomous'. On the Response of Other

Table 11 Early phase of therapy primary CCRT-LU formulations for all patients

	EARLY PHASE OF THERAPY		
Patient	**WISH**	**RESPONSE OF OTHER**	**RESPONSE OF SELF**
1 Quin	C2 Loving, Having relationship	L1 Annoying someone	F2 Being scared, Anxious
2 Gerta	A2 Accepting, Understanding	J2 Opposing, Criticising	F2 Being scared, Anxious
3 Sally	D2 Being proud, Being autonomous	K2 Dominating	H2 Being disliked
4 Artie	C1 Being close	J2 Opposing, Criticising	F2 Being scared, Anxious
5 Quoit	B2 Helping, Giving independence	J1 Ignoring, Reproaching	H1 Feeling disgust, Being angry
6 Carla	A2 Accepting, Understanding	I1 Neglecting	G2 Being Weak
7 Amal	D2 Being proud, Being autonomous	K2 Dominating	F2 Being scared, Anxious
8 Troy	A2 Accepting, Understanding	J2 Opposing, Criticising	F1 Feeling guilty, Being dissatisfied
9 Karen	A1 Exploring, Admiring	J2 Opposing, Criticising	J2 Opposing, Criticising
10 Ken	D2 Being Proud, Being autonomous	J1 Ignoring, Reproaching	G2 Being Weak
11 Kim	C4 Being sexually active, Interested	C4 Being sexually active, Interested	F2 Being scared, Anxious
12 Leah	C2 Loving, Having relationship	K2 Dominating	F1 Feeling guilty, Being dissatisfied
13 Tara	C1 Being close	I1 Neglecting	C3 Being confident, satisfied, experiencing pleasure
14 Wyn	D2 Being proud, Being autonomous	K2 Dominating	F2 Being scared, Anxious
15Victor	D1 Being moderate, Trustworthy	I1 Neglecting	H1 Feeling disgust, Being angry
16 Sue	B1 Explaining, Confirming	I1 Neglecting	G2 Being Weak
15 Kris	C1 Being close	J2 Opposing, Criticising	G2 Being Weak

component for the same patients and within the early phase of therapy, six themes were represented from a possible nineteen categories, five of which were dispersed across the Disharmonious dimension. The J2 mid-level category 'Opposing, Criticising' occurred most frequently. There were seven mid-level categories represented in the Response of Self component six of which were located in the Disharmonious dimension and one in the Harmonious Dimension. The most frequently occurring RS mid-level category was F2-'Being Scared, Anxious'. Table 12 illustrates the interpersonal patterns from the middle and end phase of therapy for the same sub-sample of five patients, whose tailor-made and QUAINT profiles has been described in previous sections. The data is also reported at the CCRT-LU's mid-level category. The CCRT-LU categories, in particular at the cluster- and mid-level's, read as fairly broad themes which stand separate from

Table 12 Middle and end phase of therapy primary CCRT-LU formulations for two most-improved, one mixed-improved and two least-improved patients

	Patient	MIDDLE Component & CCRT-LU mid-level category		LATE Component & CCRT-LU mid-level category	
Most Improved	4 Artie	W RO RS	NO MIDDLE THERAPY SESSIONS	W RO RS	D2 Being proud, Being autonomous C4 Being sexually active, Interested C3 Being confident, Satisfied, Experiencing pleasure
	2 Gerta	W RO RS	C3 Being confident, Satisfied, Experiencing pleasure K1 Being bad F2 Being scared, Anxious	W RO RS	D2 Being proud, Being autonomous J2 Opposing, Criticising F2 Being scared, Anxious
Mixed Improved	9 Karen	W RO RS	A1 Exploring, Admiring I1 Neglecting F1 Feeling guilty, Ashamed, Being dissatisfied	W RO RS	D2 Being proud, Being autonomous B2 Helping, Giving independence H1 Feeling disgust, Being angry
Least Improved	16 Sue	W RO RS	D1 Being moderate, Trustworthy C4 Being sexually active, Interested G2 Being weak	W RO RS	D1 Being moderate (out of strength), Trustworthy J1 Ignoring, Reproaching F2 Being scared, Anxious
	11 Kim	W RO RS	B1 Explaining, Confirming J1 Ignoring, Reproaching M1 Retreating, Being reserved	W RO RS	C1 Being close J1 Ignoring, Reproaching L1 Annoying someone

the subject- and object-directions. However, the formulations are translated into sensible expressions; e.g., patient Gerta's middle phase formulation reads "as a desire to be confident, satisfied and capable of experiencing pleasure, with the perception of others acting badly toward her to which she reacts with feelings of fear and anxiety".

2.2.3 Research Question 2: How do the QUAINT and CCRT-LU systems compare?

The weighted kappa method was adopted to investigate the comparison of the QUAINT and CCRT-LU systems. The primary CCRT formulations for each patient in each phase of therapy from the respective methodologies were matched (see Appendix F for the data comparisons and contingency table, QUAINT x CCRT-LU). That is, the observation units were based on the number of patients, the phase of therapy and the number of components. Therefore there were one hundred and twenty-nine data points [17 patients x 3 components in the early phase; plus 13 patients x 3 components in the middle phase; plus 17 patients x 3 components in the late phase; minus 12 missing data points]. The resultant weighted kappa suggests fair-moderate agreement between the two systems with a coefficient of kw = .34 (z = 8.91) on the total sample (n = 129); kw = .46 (z = 9.86) on the Wish component (n = 43); kw = .48 (z = 9.93) for the Response of Other component (n = 43) and kw = .49 (z = 9.64) on the Response of Self component (n = 43). The significance values indicate the agreement is greater than what would have expected by chance (Cohen, 1968). In short, these results allude to a weak agreement between the two methods.

It was of some interest to note subsequent analysis on a sub-set of the data set found higher agreement between the two methods. The sub-set consisted of patients at the extreme of most-improved (4 patients) (kw(all components, n = 23) = .79, z =

19.61) and least-improved (4 patients) (kw(all components, n = 33) = .62, z = 17.09). The weighted kappa coefficients and the significance values suggest the agreement is greater than chance expectations. However given the small sample size of the sub-set no conclusions can be drawn from these results.

The process of comparing the QUAINT and CCRT-LU coding system revealed areas of convergence and divergence. Table 13 lists a number of such observations. The CCRT-LU system allows for more accuracy in representing the patients' expression as well as being responsive to a greater range of relational themes. The QUAINT method includes object- subject-directed items in the expression of items as either "To be ..." or "Other to be...". The CCRT-LU method has greater flexibility in its dealing with object- subjected directed themes.

Table 13 Observations of concordance and discordance between the QUAINT and CCRT-LU categories.

CONCORDANT ITEMS	DISCORDANT ITEMS
QUAINT's *affirming & understanding* items equate with CCRT-LU's A2 category *Accepting, Understanding.*	CCRT-LU's M cluster *Withdrawing* can relate to QUAINT's *To be walling off & distancing* items. However this is not definitive as the CCRT-LU M cluster is subject to interpretation of the drive to withdraw.
QUAINT's *Freeing & forgetting* items equate with CCRT-LU's C3 category *Being Confident, satisfied, experiencing pleasure.*	The late RO component for patient Gerta *To be belittling & blaming* correlating with *To be attacking & rejecting.* The CCRT-LU K2 cluster could have been applied in this instance or alternatively the L2 category *Attacking.*
QUAINT's *loving & approaching* items equate with CCRT-LU's C1 category *Being close.*	QUAINT's *Feels powerful* items do not have an exact CCRT-LU equivalent. However, the concept can be interpreted in the CCRT-LU system in the D, Being self-determined cluster or the K2 Dominating category.
QUAINT's *belittle & blame* items equate with CCRT-LU's K cluster *Subjugating* or more specifically the category K2 *Dominating.*	The QUAINT cluster lacks specificity of items to capture themes of intimacy, especially sexual intimacy and/or passions. The relevant QUAINT items were *To be loving & approaching* and *To be joyfully connecting*; as compared to the CCRT-LU's C4 category *Being sexually active, interested.*
QUAINT's *disclose & express* items equate with CCRT-LU's B11 category *Explaining, confirming.*	The CCRT-LU code provides categories to convey sexual inactivity and withdrawal: M2 – *Being sexually inactive.*
QUAINT's *ignoring & rejecting* items equate with CCRT-LU's J cluster or more specifically at the category level 'ignoring' is the same as J1 *Ignoring, reproaching* and 'rejecting' is the same as J2 *Opposing, criticising.*	
QUAINT's *To be self-accepting and exploring* on the RS component equates with CCRT-LU's A1 category *Exploring, admiring*	

The results from the similarity ratings between the tailor-made and the CCRT-LU systems found moderate agreement on each component (see Table 14). The same series of ratings for the tailor-made and the QUAINT method showed poorer similarity. The average similarity rating on the CCRT-LU and the tailor-made were consistently higher than those ratings of the QUAINT and the tailor-made. These differences, however were negligible, are suggestive of the CCRT-LU system being more

representative of the patients actual expression. The direct ratings of similarity between the QUAINT and the CCRT-LU system produced the following average ratings for each component: W = 40; RO = 40; and RS = 28.83. These average similarity ratings suggest the CCRT formulations of each system are less than moderately comparable.

Table 14 Average similarity ratings between the Tailor-made primary CCRT formulations and the QUAINT and CCRT-LU coding systems for all patients and on each component

CCRT Component	Tailor-made vs. QUAINT [0 - 100]	Tailor-made vs. CCRT-LU [0 - 100]	*t*	p
W	20.74	56.47	3.32	.004
RO	36.76	59.12	2.48	.03
RS	28.23	46.47	2.29	.04

2.3 Conclusion

This study sought to examine the CCRT methodology's capacity to capture the interpersonal relational patterns described by patients receiving long-term psychoanalytic treatment. The author anticipated the different CCRT systems would elicit similar interpersonal relationship patterns; however the CCRT formulations would be idiosyncratic to the scoring system of the respective method (for example, the CCRT-LU scores the object- & subject-dimensions, WOS, WSO etc). The tailor-made CCRT method provides a clinical reference point for the patient's relational patterns. The QUAINT and CCRT-LU methods offer alternative coding systems.

- Both methods produced acceptable inter judge agreement ratings.

- The QUAINT method easily captures the multiple CCRT's in a manner that does not suggest a primacy of any one relational theme. The QUAINT

coding system and the cluster analysis method utilised in this study is adept in conveying the multiple and conflictual relationship themes.

- The CCRT-LU coding system also captures aspects of multiplicity of relational themes, particularly through the additional subject- and object-directed components. This system has a large vocabulary available to the judge and/or clinician.

- The CCRT-LU and the QUAINT systems showed weak-moderate agreement on the W, RO and RS dimensions (kappa .-46-.49).

- The CCRT-LU method gives a closer approximation to the tailor-made identified relationship patterns, than that achieved through the QUAINT system.

- The direct comparison of the QUAINT and the CCRT-LU methods using similarity ratings suggests the systems are less than moderately similar.

- The comparison of the QUAINT items with the CCRT-LU categories (see Table 13) illustrates the different sensitivities of the two coding systems.

Chapter 3

Study 2: An investigation of changes in CCRT patterns and their relationship to clinical measures

3.1 METHOD

3.1.1 Sample

This study shared the data with study 1 (chapter 2). That is, the same seventeen patients formed the sample.

3.1.2 Measures

CCRT-LU

The CCRT-LU system was scored as it was for the previous study; however in this study the W was scored as WO and WS components. Therefore, the distribution of components differed due to the distinction of the W component into the subject- object directed components of WO and WS. Across the entire data set 388 WO and 435 WS components were observed and scored. The number RO and RS components remained the same.

Valence

Valence ratings are applied to the RO and RS components during the tailor-made method. The valence is measured using a four-category positive and negative scale; where '1' is strongly negative, '2' is negative, '3' is positive and '4' is strongly positive. Judges rate the degree of positivity and negativity for the response of other (RO) and the response of self (RS) within each relationship episode (RE) (Grenyer & Luborsky, 1998). The concepts of positivity and negativity refer to the extent to which

the satisfaction of the Wish is achieved (positivity) or intruded upon (negativity) (Grenyer & Luborsky, 1998). For example, if in a patients narrative, the wish is to be 'independent', the response of other is 'controlling' and the patients' response is to 'give-in', the valence for both the RO and RS would be 1 - mostly negative or 2 - negative, depending on the judges appraisal of the intensity. Alternatively, if in the narrative, the RS was to 'protest' against the other's controlling then a more positive valence (a 3 - positive or 4- mostly positive) would be applied as the RS works towards satisfying the wish. The valence scores for the RO and RS component are averaged across each phase of therapy, per patient.

Pervasiveness

It is thought the more pervasive the relationship conflicts the more likely a person will demonstrate symptoms of psychological distress (Crits-Christoph & Luborsky, 1998). Therefore, a reduction in maladaptive relationship themes over the period of therapy may be used to indicate change. In this study, pervasiveness was estimated by the dispersion of distinct relationship themes, as measured by the CCRT-LU system. This analysis was conducted on the CCRT-LU categories (30) across phases of therapy and consisted of a proportional statistic: Pervasiveness = Number of Endorsed Categories/Total Number of Categories (N=30). Whereas Crits-Christoph and Luborsky (1998) calculated pervasiveness across relationship episodes (number of RE's/total number of RE's), this study relied on the phase of therapy as the unit of analysis to indicate the dispersion of relationship conflicts. This method was based on the rationale that in psychoanalysis the nature of free association meant the relationship episodes were characterised as long, fragmentary and frequently intruded on by digressions of thought; and therefore, the period of time between phases provided a

greater opportunity to show the variety of transference patterns. Conversely, in short term therapy the interpersonal narratives are more distinct; hence the CCRT across relationship episodes is the more sensitive measure. In short, the phase of therapy considered as to be an equally valid unit of analysis on which to calculate pervasiveness.

This proportional equation was applied to each patient, and due to the non-significant thematic shifts in the middle phase and the small numbers of patients with middle session data; these calculations were only performed on the early and late phase of therapy. Furthermore, the pervasiveness of CCRT-LU themes was only calculated on the RO and RS components as the WO and WS components demonstrate relative stability over time (e.g., see Figures 6 & 7) both in this sample and in previous studies.

Harmonious and Disharmonious Dimensions

Change in relationship patterns from early to late stages of therapy was calculated as a proportional change in Harmonious and Disharmonious categories over time. The proportional change in the Harmonious and Disharmonious categories was calculated by converting the absolute frequencies of positive and negative categories into a proportional statistic to be called 'harmony': Harmony = Number of Harmonious Categories/ Σ(Number of harmonious categories + Number of disharmonious categories). This Harmony statistic was calculated for each patient on the four CCRT-LU components [WO, WS, RO and RS] and at each stage of therapy.

Clinical Outcome Measures

Clinical outcome measures were made available for use in this study and have been reported elsewhere (Luborsky et al., 2001; Martin, 2003). Early and late sessions

from each patient were rated by independent clinicians experienced in psychodynamic psychotherapy and in the use of measures of psychiatric severity (Luborsky et al., 2001; Martin, 2003). These measures included: the Health-Sickness Rating Scale, the Global Assessment of Functioning, the Mastery Scale, and a combination of success, satisfaction and improvement measures (Luborsky et al., 2001). Roth and Fonagy (1996) recommend that outcome measures ought to be drawn from a variety of domains including perspectives of significant others, an array of symptomatology as well as indicators of functioning in differing spheres of an individual's life. Outcomes measures are often criticised as being insensitive to the complexities of the individual's presentation, especially when the patients' presentation is reduced to a symptom profile (Roth & Fonagy 1996). The CCRT methodologies are designed to capture the subtleties of the patient, in the form of intrapsychic processes (Crits-Christoph, 1998; Luborsky, 1998a, 1998c, 1998d; Albani et al., 2003); and the applications of allied clinical measures are intended to complement the clinical and research findings.

The *Health-Sickness Rating Scale* (HSRS) has a global scale as well as seven criterion graphic 100 point scales that reflect the patients degree of functioning of: disturbance to personality organisation; subjective distress; the capacity to participate in vocations/daily activities; the quality of interpersonal interactions and leisure interests; the degree to which the individual effects the environment, e.g. threat of danger (Luborsky et al., 1988; Luborsky et al., 2001). The HSRS was used in an early investigation of the reduction of pervasiveness of conflicts over the course of therapy (Crits-Christoph & Luborsky, 1998). The application of the HSRS has demonstrated a relationship between a change in CCRT pervasiveness and a change in symptom levels (Luborsky et al., 1988; Crits-Christoph & Luborsky, 1998). Two HSRS scores for each

patient were used in the analysis: one was the global score and the other an average of the seven criterion scores (Luborsky et al., 2001).

Global Assessment of Functioning (GAF) scores provide a single measure of an individual's level of functioning as reported by the clinician's assessment of psychological, social and occupational functioning (APA, 1994). The GAF scale is based on the Health Sickness Rating Scale that was developed at the Menninger Foundation (Luborsky, Diguer et al., 1993). It is considered to be a useful measure of clinical progress (APA, 1994) and its sensitivity to change has been reviewed as moderately good (Luborsky et al., 1993). Hilsenroth et al. (2000) demonstrated the reliable scoring of the GAF. A more recent study by Bacon, Collins and Plake (2002) found high inter-rater reliability; however, their investigation also concluded the GAF is sensitive to factors such as the severity of symptoms and therefore, not exclusively issues of functioning (Bacon, Collins & Plake, 2002). Piersma and Boes have reported on similar and additional concerns (1997). It could be argued these concerns are of little importance as factors such as the severity of symptoms are inextricably part of a person's functioning. Regardless, the GAF scale continues to be a commonly used clinician-rated scale (Piersma & Boes, 1997). The GAF scale was applied to the patients within this data set retrospective to the end of treatment and was employed as a measure of therapeutic outcome (Luborsky et al., 2001).

The *Success*, *Satisfaction* and *Improvement* (S.S.I.) ratings are measures of treatment improvement and are therefore applied toward the end of a course of therapy (Luborsky et al., 2001). These individual measures correlate well and were combined and averaged producing a single score (Luborsky et al., 2001).

The *Mastery Scale* measures a patient's acquisition of self-control and self-understanding in the context of interpersonal relationships and the mastery scale has been demonstrated as a reliable and valid measure of the process and outcome of psychotherapy (Grenyer & Luborsky, 1996). The Mastery Scale incorporates dynamic concepts that are considered to be indicative of self-control and self-understanding. The Scale has three levels: Scores 1 and 2 relate to failures of mastery of manifest problems; Scores 3 and 4 relate to the struggle to improve; and, Scores 5 and 6 demonstrate good levels of mastery (Grenyer & Luborsky, 1996). Relationship episodes are identified within verbatim transcripts, clauses are delineated and a Mastery Score is applied to the individual clause. The basic scoring process produces a single score (valued between 1 and 6) which is determined by the sum of mastery scores, divided by the number of scored clauses (Grenyer, 2002). The application of the mastery scale to the data set under investigation in this project will enable a comparison with previous research. Furthermore, it has been used in conjunction with other outcome measures (e.g. HSRS) as each measure has a slightly different domain of assessment and therefore it is not useful for the research to establish a statistical compilation of outcome variables. It is anticipated that the findings from the mastery scoring will support the results obtained in the CCRT analysis as evidenced by an increment in the mastery scores as therapy progresses, which will parallel changes in pervasiveness, valence and increases in harmonious components.

3.1.3 Procedure

Investigating the CCRT Patterns in Psychoanalysis

The aim of this thesis was to explore the relational patterns of patients receiving long-term psychoanalysis. Based on the findings from the first study, the CCRT-LU

system was selected as the preferred method to investigate the CCRT patterns within this particular psychoanalytic data set. In particular, the CCRT-LU method was favoured as it was found to be similarly sensitive to the patient's expression as to the tailor-made method; it is easy to score and has demonstrated reliability (Albani et al., 2002). The data was scored as per the tailor-made method, with the assigning of valence to the RO and RS components. The CCRT-LU category system was then used to standardise the patient's expressions. The thought units within each RE were recorded as the CCRT-LU components [WOO, WOS, WSO, WSS, ROO, ROS, RSO and RSS] on summary sheets; however, only the four components [WO, WS, RO and RS] were retained for analysis as these capture the essence of the interpersonal interaction. The most frequent of each component contributed to the CCRT-LU formulation.

3.1.4 Data Analysis and Statistical Inference

Analyses of Change

Calculations related to valence, pervasiveness and harmony were performed to ascertain the change in interpersonal relationship patterns from early to late stages of therapy. Therefore, a one-way repeated measured ANOVA was performed on each index (valence, pervasiveness & harmony) to determine an estimate of change between early and late phase of therapy. On the harmony index the ANOVA's were repeated with the exclusion of the M category from the Disharmonious dimension, as it has been noted the M cluster and associated categories and subcategories can be interpreted as both harmonious or disharmonious depending on the context (Dan Pokorny, personal communication, June 2003).

Residual change scores were calculated for the valence, pervasiveness and harmony indices and on the clinical measures (Mastery Scale, GAF, HSRS & SSI) (Cronbach & Furby, 1970; Luborsky et al., 1988).

Finally, the residual change calculations were used in a sequence of Pearson's correlations to investigate the relationship between the change indicators, valence, pervasiveness and harmony scores and the clinical measures that had been applied to the data in previous investigations: the HSRS, the GAF scores and S.S.I. ratings (Luborsky et al. 2001) as well as the Mastery Scale (Martin, 2003). As the hypothesis predicts a particular direction, for example, a higher valence on the RO and the RS will correlate with improvement on the clinical measures, a one-tailed test was set on the Pearson's correlation.

Statistical Inference

For all analyses the criterion for statistical significance was p .05, unless otherwise specified.

3.2 Results

Research Aim

To examine the relational patterns of patients receiving long-term psychoanalysis, as indicated by harmony, pervasiveness and valence measures as well as measures of clinical outcome.

Hypotheses

- Relational patterns will become more positive (harmonious) over the course of therapy.
- A dispersion of CCRT-LU categories will be observed across the course of therapy.
- The patient's freedom to act will increase as indicated by an increase in the valence on both the response of other [RO] and the response of self [RS] components.
- The change in valence, harmony and pervasiveness scores will correlate positively with the changes in clinical measures, the GAF, the Mastery Scale, the H.S.R.S. and the S.S.I.

3.2.1 Research Question 1: To what extent are CCRT patterns modifiable?

Harmony

The Harmony calculations were used to demonstrate changes in CCRT patterns across therapy. A significant difference was obtained between early and late phase therapy on the RS component at both the categories $F(1,16) = 10.58$, $p = .005$ and the

clusters $F(1,16) = 5.89$, $p = .03$. The changes at the category level are illustrated in Figures 1 and Figure 2 and suggest a trend of patients' response of self acquired more positive themes in the late stage of therapy. The change in the RO from early to late therapy was not found to be significant at either the cluster $F(1,16) = 2.79$, $p = .11$ or category $F(1,16) = 3.63$, $p = .08$ level of abstraction. Figure 2 charts a change process from the early phase of therapy, through the middle phase and at the end phase of therapy for those 13 patients with middle transcript data. A drop in the patients' experience of the other in positive terms between the early and middle phases of therapy is shown. However, at the late stage of therapy the RO component had increased to above early stage indicators of harmony. As expected, there was little variation between the WO and WS components from early to late phase therapy (see Figure 1), as reflected by the lack of significance found at either scoring level: at the cluster $F(1,16) = .003$, $p = .96$ and at the category $F(1,16) = .00$, $p = 1.00$ on the WO component; and on the WS component at the cluster $F(1,16) = .22$, $p = .64$ and at category $F(1,16) = .002$, $p = .96$ level of abstraction. Figure 2 includes the data from the middle phase of therapy (N=13). A small increase is evident in Harmony on the WO and WS components between the early and middle phase of therapy; however, a drop to below early levels was noted on the WO component in the late phase of therapy and the WS fell from the levels of Harmony gained in the middle phase. Greater shifts in the RO and RS components in Figure 2 are noted between middle to end phase of therapy than that achieved between early and middle stages of therapy. The trends evident at the category level (Figure 1 and Figure 2) are paralleled in those calculations performed at the cluster level (see Appendix G).

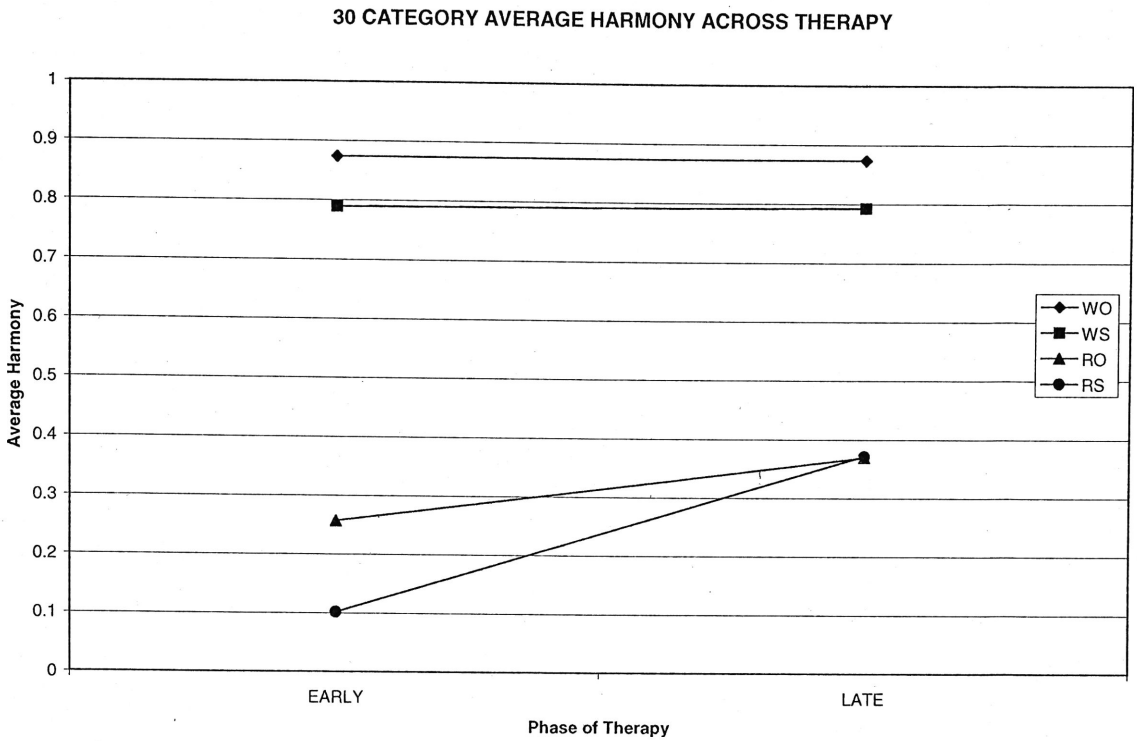


Figure 1 Average harmony across therapy for 17 patients (early and late phase of therapy)

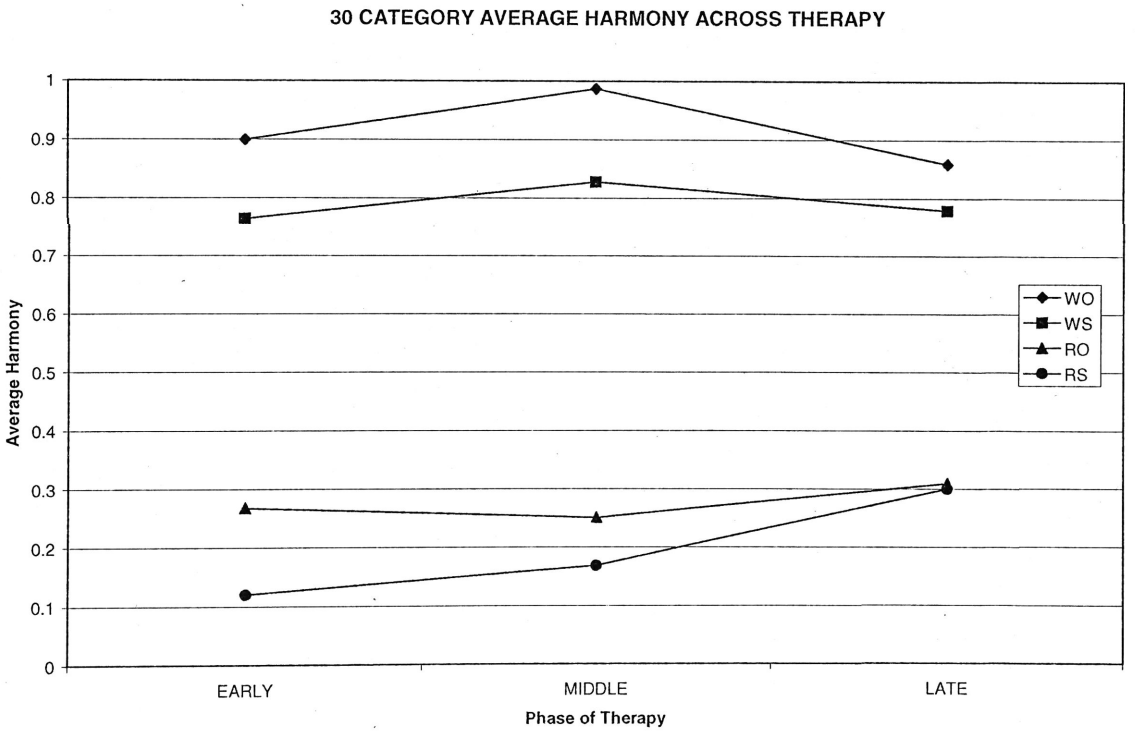


Figure 2 Average harmony across therapy for 13 patients (early, middle and late phases of therapy)

A repeat analysis on the same data was conducted with the 'M' category excluded in order to determine if this category was confounding the results (Dan Pokorny, personal communication, June 2003). This analysis revealed similar results to the original findings. Significance difference from early to late phase of therapy were only evident on the RS component at both the category $F(1,16) = 10.19$, $p = .01$ and the cluster $F(1,16) = 5.77$, $p = .03$ level of abstraction.

Pervasiveness

The average proportion of CRT-LU categories represented in the early phase of therapy, for both RO and RS components, was slighter greater than the average

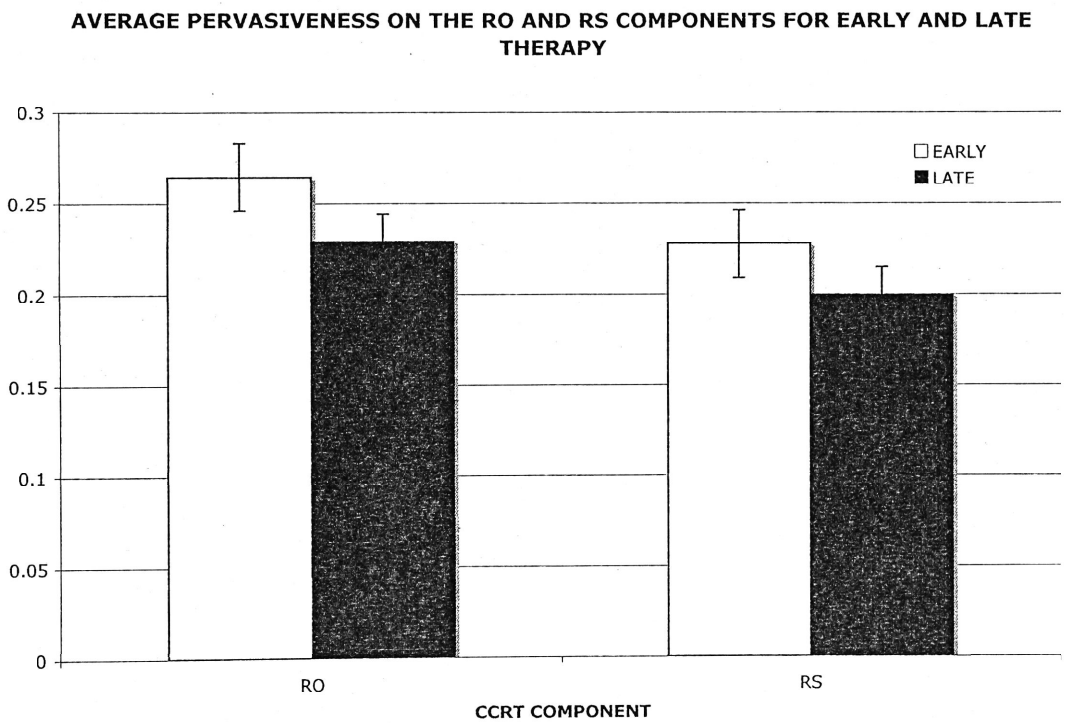


Figure 3 Comparison of average pervasiveness on the RO and RS components for all patients (N=17) from early to late therapy

proportion of themes represented late in therapy (Figure 3). The difference on each component was not found to be significant: the mean pervasiveness on the RO

component early in therapy was .26, and late in therapy was .23. On the RS component, the average early pervasiveness was .23 and late in therapy the mean pervasiveness score was .2. These findings indicate that toward the end of therapy there was no change in the number of CCRT-LU categories representing the patients interpersonal relationship themes. This study does not accord with previous research. Previous studies report a shift toward a greater number of relational themes within interpersonal narratives late in therapy as associated with improvement (Crits-Christoph & Luborsky, 1998). However, this method of calculating the spread of categories is not an exact measure of pervasiveness, as it does not factor the complexities of the change process. For example, the proportional calculation did not consider the shift in distribution from Disharmonious to Harmonious categories. These finding suggest this index of change cannot be interpreted in isolation of other measures. It may be that for this sample, the spread of CCRT component is less important than the type of components. That is, the spread of CCRT patterns may stay relatively rigid, but the content of theme is more positive and harmonious.

Valence

A significant change in valance from early to late therapy was observed on the RS component: $F(1,16) = 17.02$, $p = .001$. The finding suggests the importance of the RS component. The overall changes in valence across the course of therapy for all patients are illustrated in Figures 4 and 5. This data is presented as an average valence for all patients (N=17 for early and late therapy; N=13 for middle phase of therapy) across the three stages of therapy. These average valence ratings all fall within the negative descriptors [1 = mostly negative & 2 = negative]; however there is a trend toward more positive valence by the end of therapy on both the RO and RS

components. The pattern of on the RO component appears to parallel the pattern on the RS component, regardless of the lack of significant difference from early to late. That is, there was little change in valence between the early and middle phases of therapy, leaving most of the change in transference phenomena to occur between the middle and late stage of therapy.

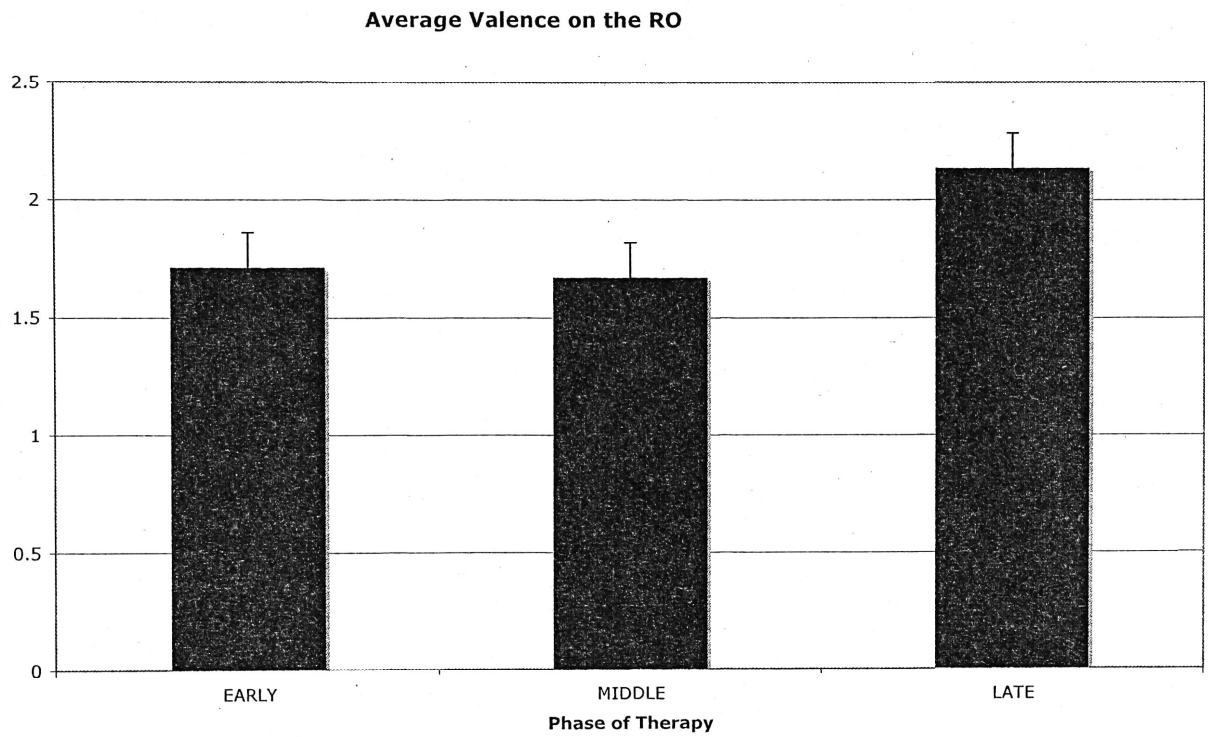


Figure 4 Average valences on the RO component for all patients (early & late, N=17; middle N=13)

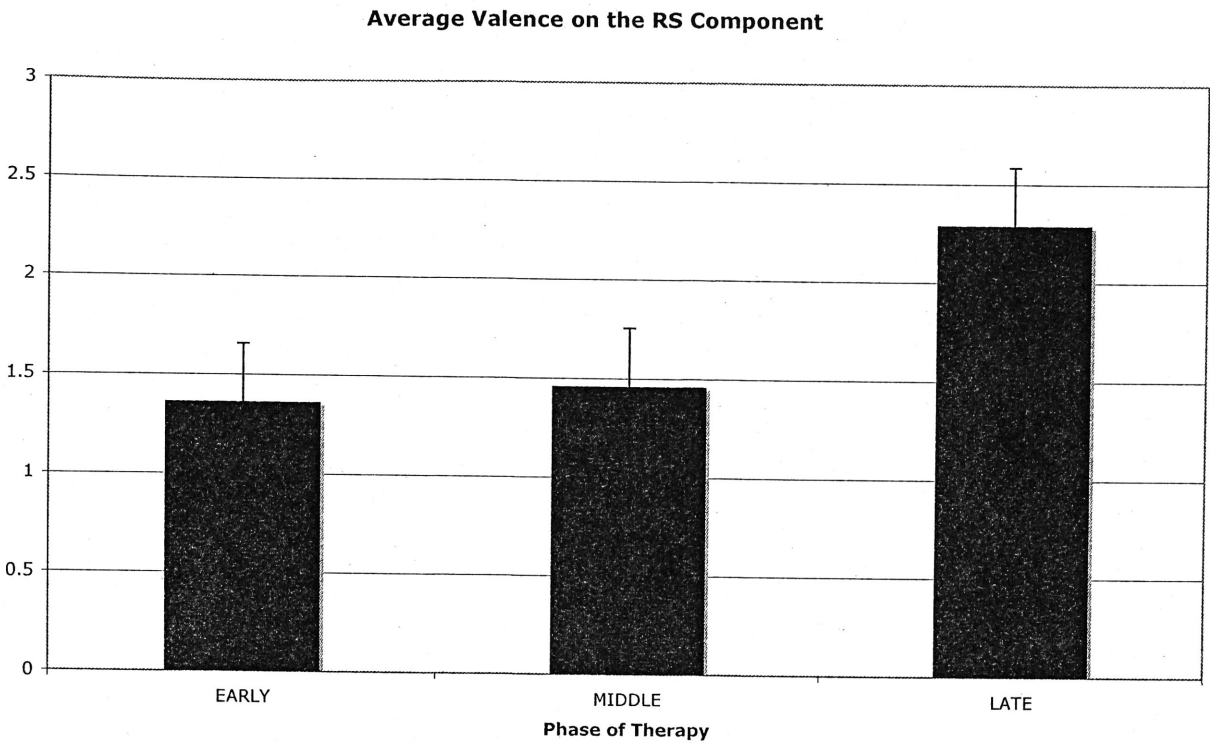


Figure 5 Average valences on the RS component for all patients (early & late, N=17; middle, N=13)

3.2.2 Research Question 2: How do these results relate to clinical outcome measures?

To demonstrate relationships between clinical outcome measures and the harmony, pervasiveness and valence scores a series of Pearson's correlations were performed (see Table 15). All the calculations were based on residual change scores. There was a significant relationship between the change in Mastery Scale scores over therapy and the RS valence change which is suggestive of the patients' sense of change in their experiences, perhaps specifically around the mastery qualities of self-control and/or self-knowledge. This indication the patients have acquired better coping skills has also been captured by the strong relationship between Mastery Scale scores and the RO and RS harmony calculations. Whereas valence captures an element of the individuals' psychological disturbance (and conversely the psychological well-being), the harmony index reflects positive relational themes and may give an affective quality to the relationship experiences. These two indices are capable of substantiating one

another. The lack of a significant relationship between the RO valence and the measure of mastery suggests less change on the RO component, which parallels the absence of statistical significance between early and late phase valence on the RO component. Nevertheless, this finding corresponds with observations that negative responses of others persist (Albani et al., 1999). The RO and RS components on the pervasiveness index also failed to demonstrate a significant correlation with change in mastery scores which is also commensurate with the failure to attain statistical significance on change between early and late phase pervasiveness. This suggests the lack of change in the number of response themes is not reflected in a person's sense of agency, or mastery.

Table 15 Pearson Correlations, using residual change scores, between valence, pervasiveness and harmony and clinical outcome measures

	VALENCE		PERVASIVENESS		HARMONY	
SCALE	**RO**	**RS**	**RO**	**RS**	**RO**	**RS**
MASTERY	.40	**.47***	.09	.1	**.54***	**.68***
G.A.F.	.24	.10	**.47***	**.44***	.26	.33
H.S.R.S.^	.30	.13	**.42***	**.51***	.28	.31
S.S.I.	.27	.05	**.48***	**.45***	.37	**.45***

* $p < .05$ level (1-tailed) ^H.S.R.S. Global scores

The significant correlations between the RO and RS pervasiveness components and the GAF, HSRS and SSI measures are an anomaly given the lack of significant change between early and late pervasiveness. These correlations suggest patients improved in spite of little change in pervasiveness. This is most likely attributable to the probability the late phase pervasiveness components comprised of more harmonious components, without a corresponding increase in number of components. Further

investigation indicated residual pervasiveness is independent of residual valence (r = -.34, p = .19) and residual harmony (r = -.16, p = .53). In a study of this nature where there are a number of outcome variables available, it is tempting to use all calculations on every variable. However, such extensive calculations lead to the possibility of type-1 errors. The inter-correlations between the variables are provided in Table 16. Since all variables are inter-correlated the choice is to either use a composite of all four variables or to select one. The problems with making a composite have been mentioned; therefore to make the study more comparable with others the HSRS scores were chosen. The stepwise regression found residual pervasiveness (F = 6.26, p = .03) and residual mastery (F = 8.68, p = .01) accounted for 54.2% of the variance on improvement (H.S.R.S.-Global); F(1,16) = 8.297, p = .007; where the criteria for stopping was set at <= .05. This suggests pervasiveness is an important indicator of progress and in this analysis the findings imply improvement corresponds with fewer relational themes. Alternatively, this can be interpreted as patient's improvement is reflected by fewer relationship conflicts. The findings in relation to the pervasiveness index, albeit meaningful, must be conservatively interpreted given the lack of significant change over time.

Harmony on the RS component was significantly related to the composite score for the Success, Satisfaction and Improvement clinical measure. This finding contributes to the validity of the 'response of self' aspect of the CCRT formulation and in particular suggests the representation of positive themes manifest as indicators of treatment improvement.

Table 16 Pearson Correlations between clinical outcome measures HSRS, GAF, SSI and Mastery Scale

Outcome Measure	HSRS	GAF	SSI	Mastery Scale
HSRS^		--	--	--
GAF	.97*		--	--
SSI	.80*	.79*		--
Mastery Scale	.58*	.59*	.70*	

* $p < .05$ level (1-tailed) ^H.S.R.S. Global scores

3.2.3 Research Question 3: What are the CCRT patterns of patients receiving long-term psychoanalysis?

The CCRT patterns of patients receiving psychoanalysis obtained through the use of the CCRT-LU system will be described in three sections. First, the data across all patients will be portrayed at the dimensional level of Harmonious/Disharmonious. Second, the obtained patterns across all patients will be illustrated at the CCRT-LU cluster level. Finally, the results from a sub-sample of the patients will be used to display the relational patterns obtained from scoring at the category level.

Distribution of the relational patterns at the CCRT-LU dimensional level

Figures 6 through to 9 illustrate the distribution of interpersonal relationship themes for all patients' at the CCRT-LU's dimensional level. The categories comprising of the Harmonious dimension are prominent for both the WO and WS components. Furthermore, there is little variation in frequency of dimensional themes over the course of therapy. Conversely, the Disharmonious categories dominate the profile for the RO and RS components in all three phases of therapy, regardless of the trend of positive

categories increasing and negative categories decreasing from early to late stages of therapy.

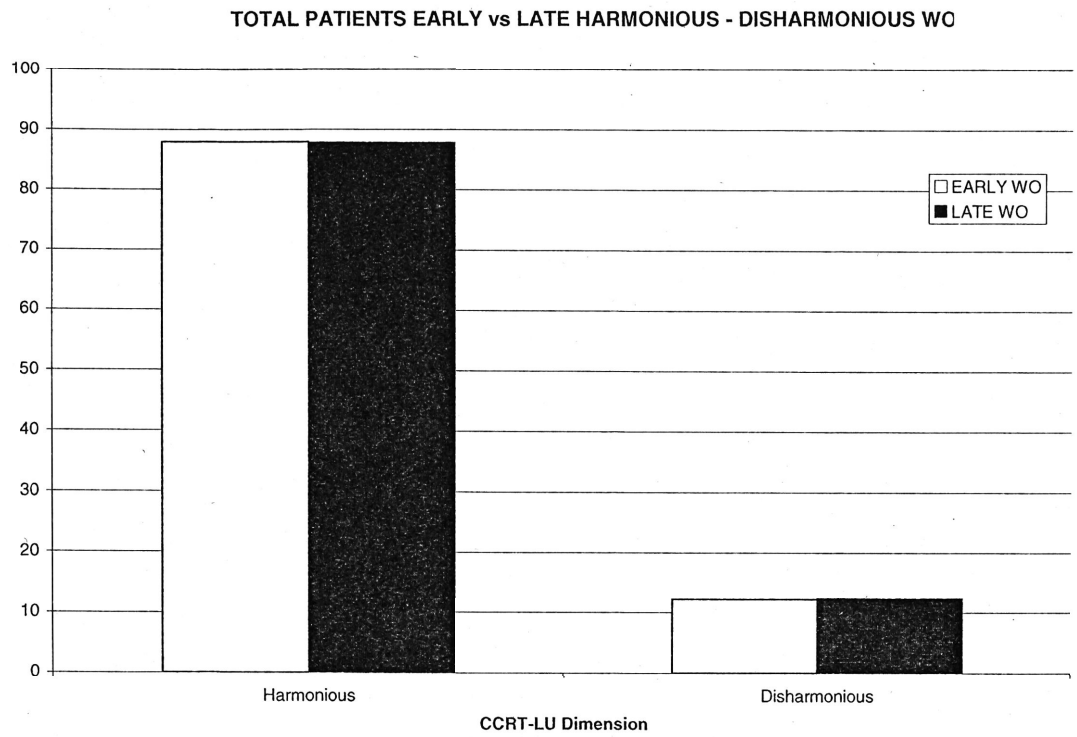


Figure 6 Changes in Harmonious and Disharmonious CCRT-LU Categories on the WO component for all patients (N=17)

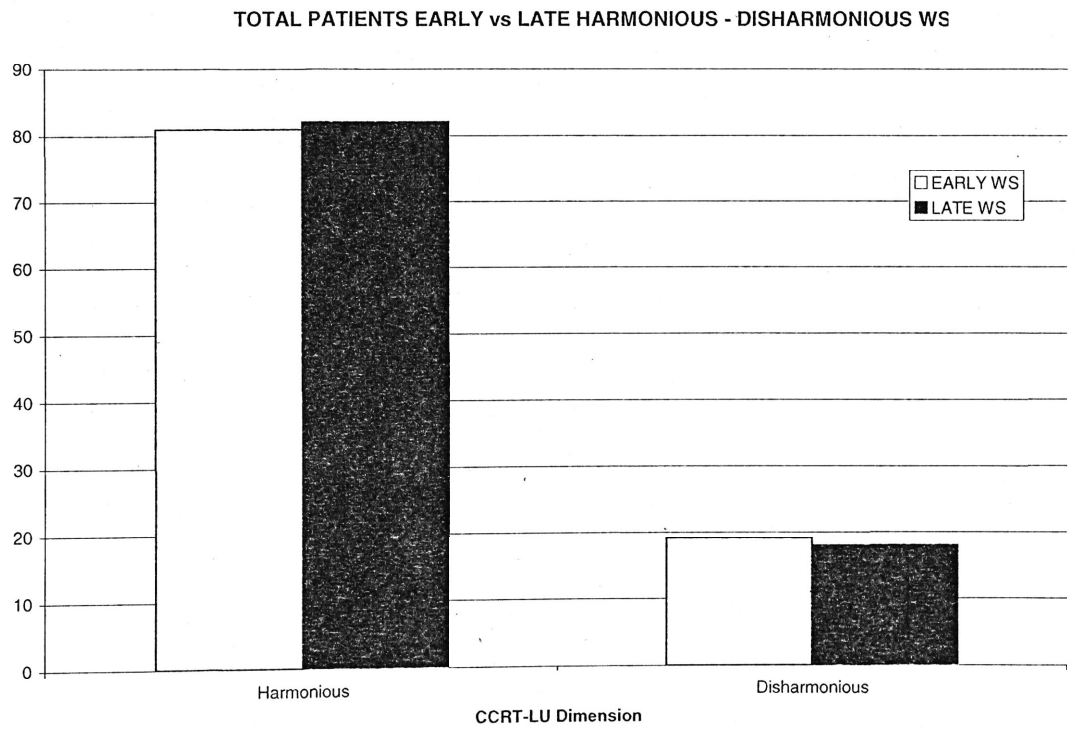


Figure 7 Changes on Harmonious - Disharmonious CCRT-LU categories on the WS component for all patients (N=17)

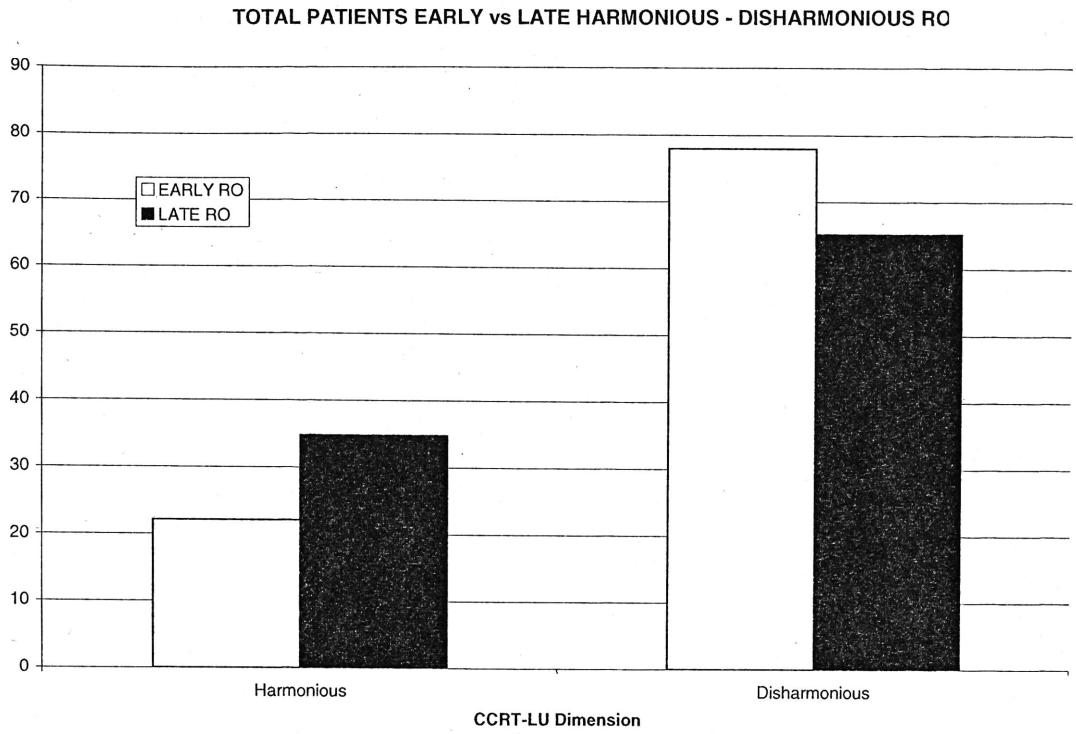


Figure 8 Changes in Harmonious - Disharmonious CCRT-LU categories on the RO component for all patients (N=17)

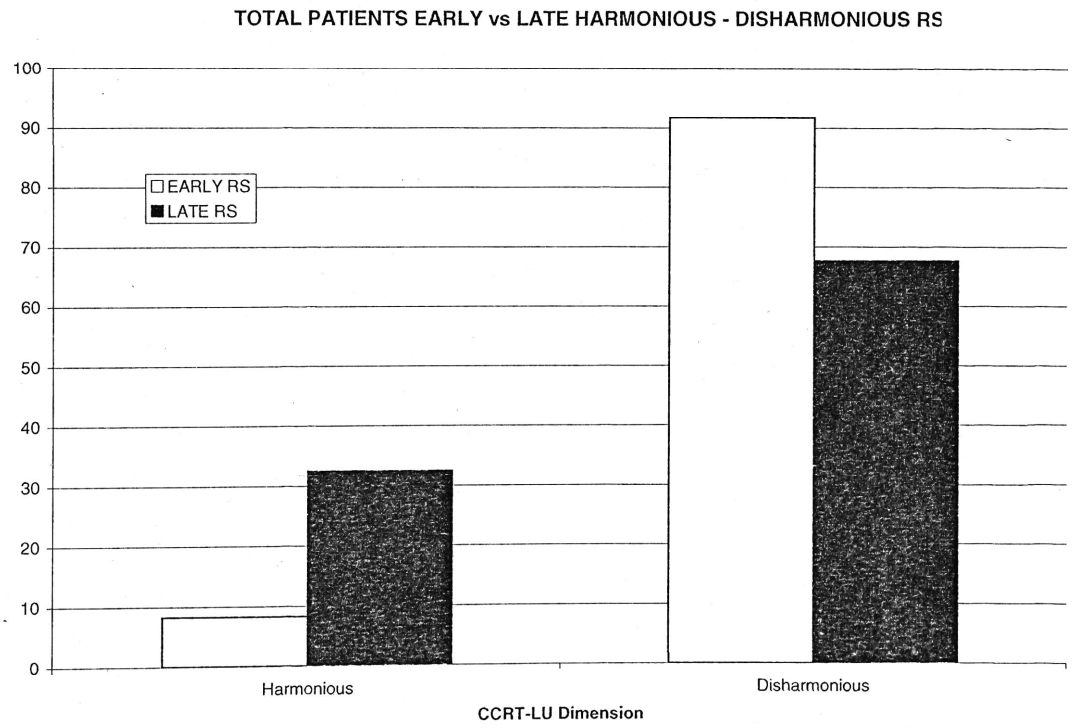


Figure 9 Changes in Harmonious - Disharmonious CCRT-LU categories on the RS component for all patients (N = 17)

Description of the relational patterns at the CCRT-LU Cluster Level

The distribution of relational themes at the CCRT-LU's cluster level parallel the distribution trends observed at the dimensional level. Figures 10-13 display the distribution of the 13 clusters for all patients on the individual components WO, WS, RO and RS. All Harmonious CCRT-LU clusters were represented on the WO component across all stages of therapy and for all patients. Clusters A-*Attending to* and C-*Loving, Feeling well* were the most frequent themes suggesting the patients were "wanting the other to attend to them" and "wishing the other to love and relate well to them". Conversely, the distribution of the clusters on the WS component conveys the patient's primary wish is to be self-determined [D-*Being self-determined*] as well as wanting to love others and for themselves to be well [C-*Loving, Feeling well*]. For both the WO and WS components the most frequent Disharmonious cluster was M-*Withdrawing*. The M cluster can be interpreted either positively or negatively. For example, a patient's wish to leave or create some distance in a relationship may be an appropriate act of power in the interpersonal situation.

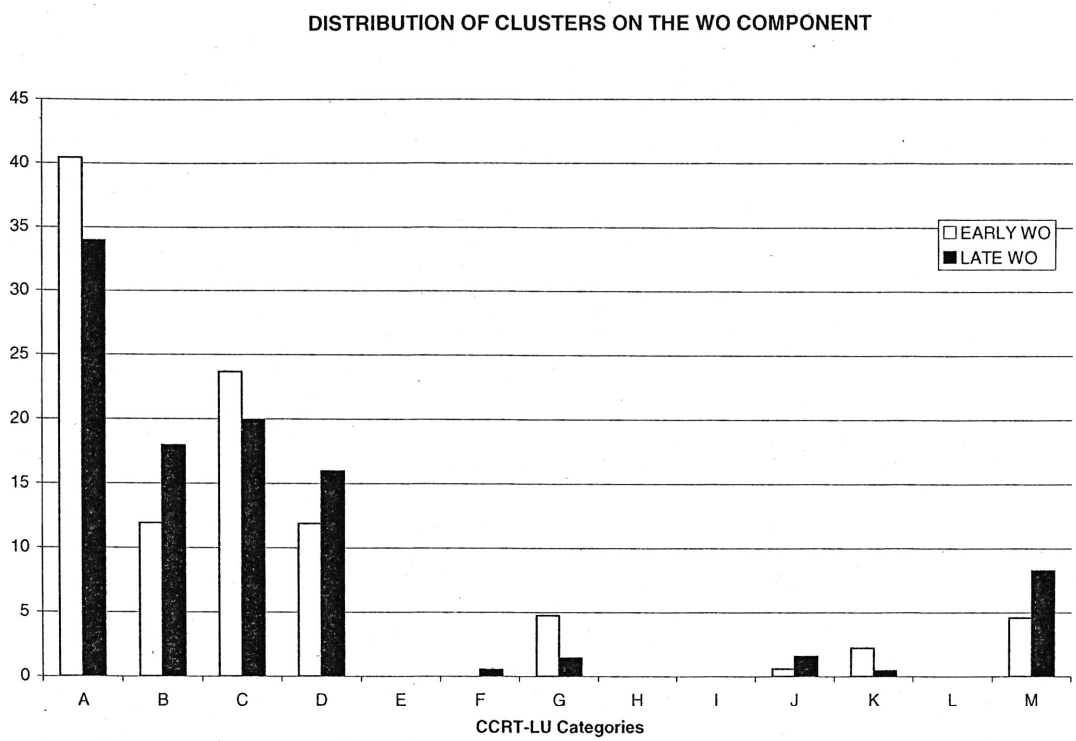


Figure 10 Distribution of CCRT-LU clusters on the WO component for all patients early and late therapy (N=17)

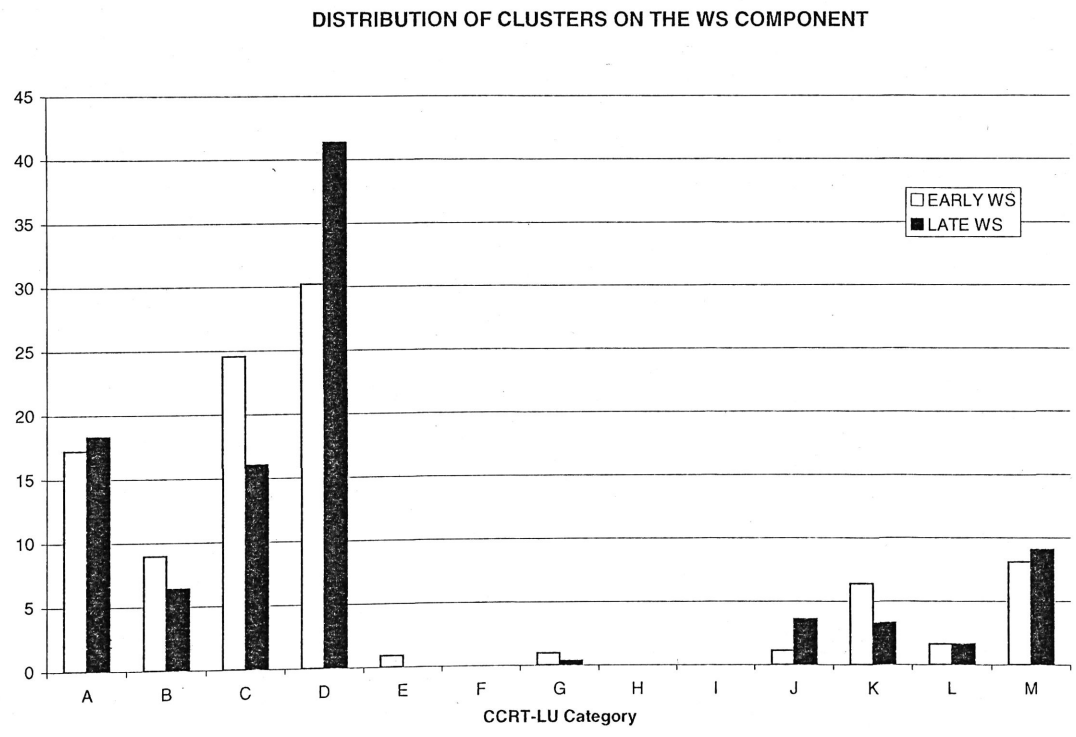


Figure 11 Distribution of CCRT-LU clusters on the WS component for all patients early and late therapy (N=17)

The profile of the all patients' Response of Other is detailed in Figure 12. The cluster J-*Rejecting* maintained the position of the most frequent relational theme across the phases of therapy. The level of frequency on several other Disharmonious clusters [clusters F, G, I, and K] also dropped. Small increases in frequency were observed on the E, H, L and clusters. Frequency increments on the RO component over the course of therapy were noted in all of the Harmonious clusters.

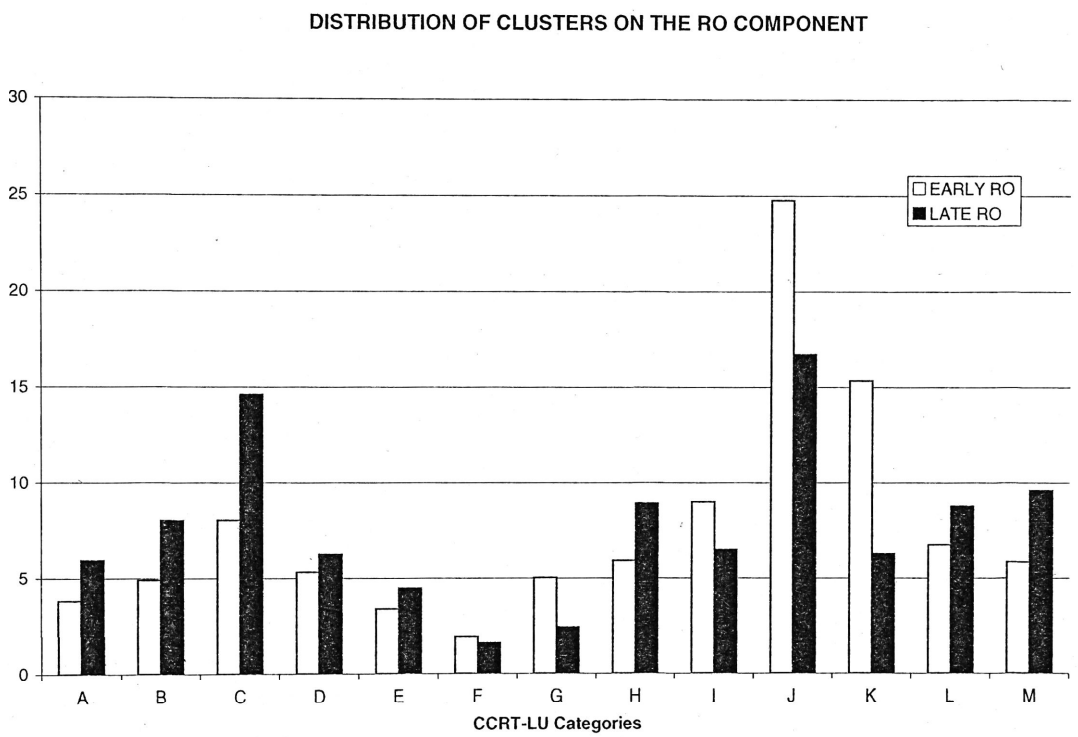


Figure 12 Distribution of CCRT-LU clusters on the RO component for all patients early and late therapy (N=17)

The frequency trends evident on the RS component (Figure 13) illustrates a preponderance of fear and dissatisfaction, F-*Being dissatisfied, Being scared*, as well as an inclination of G-*Being determined by others*. Figure 13 depicts a reduction in frequency on these clusters. With the exception of cluster B-*Supporting*, the Harmonious clusters [A, C and D] gained in frequency over the course of therapy. Other features of this distribution of RS relational themes over the course of therapy as

captured by the CCRT-LU system include: an increase in experiences of E-*Being Depressed and Resigning to something*; a slight but notable increment in L-*Annoying and Attacking* responses toward the other as well as a higher frequency of K-*Subjugating* at the end of therapy. The occurrence of I-*Being unreliable* was restricted to the early stage of therapy. This population of patients displayed few tendencies toward responding in the manner of J-*Rejecting*; any such inclinations became fewer over the period of therapy.

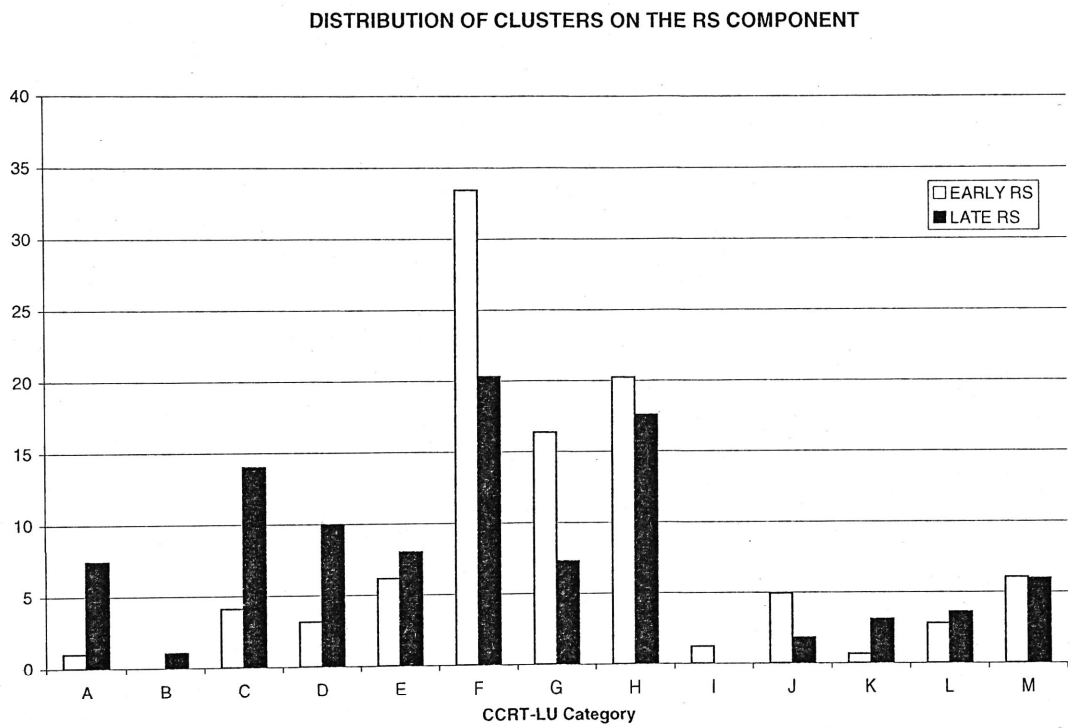


Figure 13 Distribution of CCRT-LU clusters on the RS component for all patients early and late therapy (N=17)

Description of relational patterns at the CCRT-LU Category Level: Three case studies

To illustrate the CCRT-LU categories the primary relational patterns of three patients are presented in Figure 14. The complete distribution of CCRT-LU categories for the same patients can be found in Appendix H.

(1) Patient Gerta was a woman aged 35 years old toward the end of her fourth year of psychoanalysis. She was married with two children. Assessment of her psychoanalytic transcripts highlighted features of Avoidant personality disorder, at the neurotic level of character organization (Martin, 2003). At the commencement of psychoanalysis, Gerta displayed moderate symptoms and/or moderate impairment in social or occupational functioning as indicated by the retrospectively applied GAF score. Behaviourally her symptoms manifested as her avoidance of situations that evoked fear. She exhibited strong psychosomatic responses such as nausea and vomiting. By the end of therapy, the re-appraised GAF rated mild symptoms and impairment. Gerta's Mastery Scale scores suggest she developed self-understanding and self-control by the end of therapy, which manifested as self-assertion (Martin, 2003) and corresponds to the CCRT-LU category A1 – *Exploring, Admiring*. Her avoidant behaviours were almost absent; however she continued to experience some discomfort in certain situations. The average transference valence on the RO component shifted from 'mostly negative' (1.69) during the early phase of therapy to 'positive' (2.56) valence during the end phase of therapy.

Figure 14 describes Gerta's primary CCRT-LU formulations of her relational patterns for each stage of therapy. The main interpersonal narrative given by Gerta during the early phase of therapy, reflected by the CCRT-LU categories, suggested a

wish for others [WO] to be supportive and understanding of her. She particularly, wanted to have fun; however she mostly experienced others, such as her father, frowning upon her. This would invariably evoke feelings of guilty and nervousness. In the middle phase of therapy, Gerta wished to be free, to play and feel confident; yet some conflict with the wish for others to be dominant still prevailed, especially in relation to her mother. She continued to experience others yelling at her: "they get all mad and huffy and puffy and you try to stay on the good side of both of them, but sometimes I think I am scared of them . . . or scared of people . . . scared of how I'm supposed to project myself . . . ". By the end of therapy, Gerta clearly wanted equality for herself and to be more expressive and in control; as well as being close to others. In her narratives, she still spokes of others opposing her by way not be supportive or more actively ridiculing. She also continued to report feelings of nausea, upset, fear and guilt. However, she behaved quite differently. For example, toward the end of treatment, Gerta spoke of wanting to 'throw up' in response to her father's 'yelling and screaming and criticism'. Together with her therapist she was able to clarify the sick feeling related to her revulsion of her father and her wish not to be like him. She explained: "See, I've reached the point where I could take talking . . . when someone talks I can stand on my own two feet and find where I stand in the situation I don't literally take everything they say seriously like I did before . . ." She had become most active in a small business, involving a lot of interaction with others.

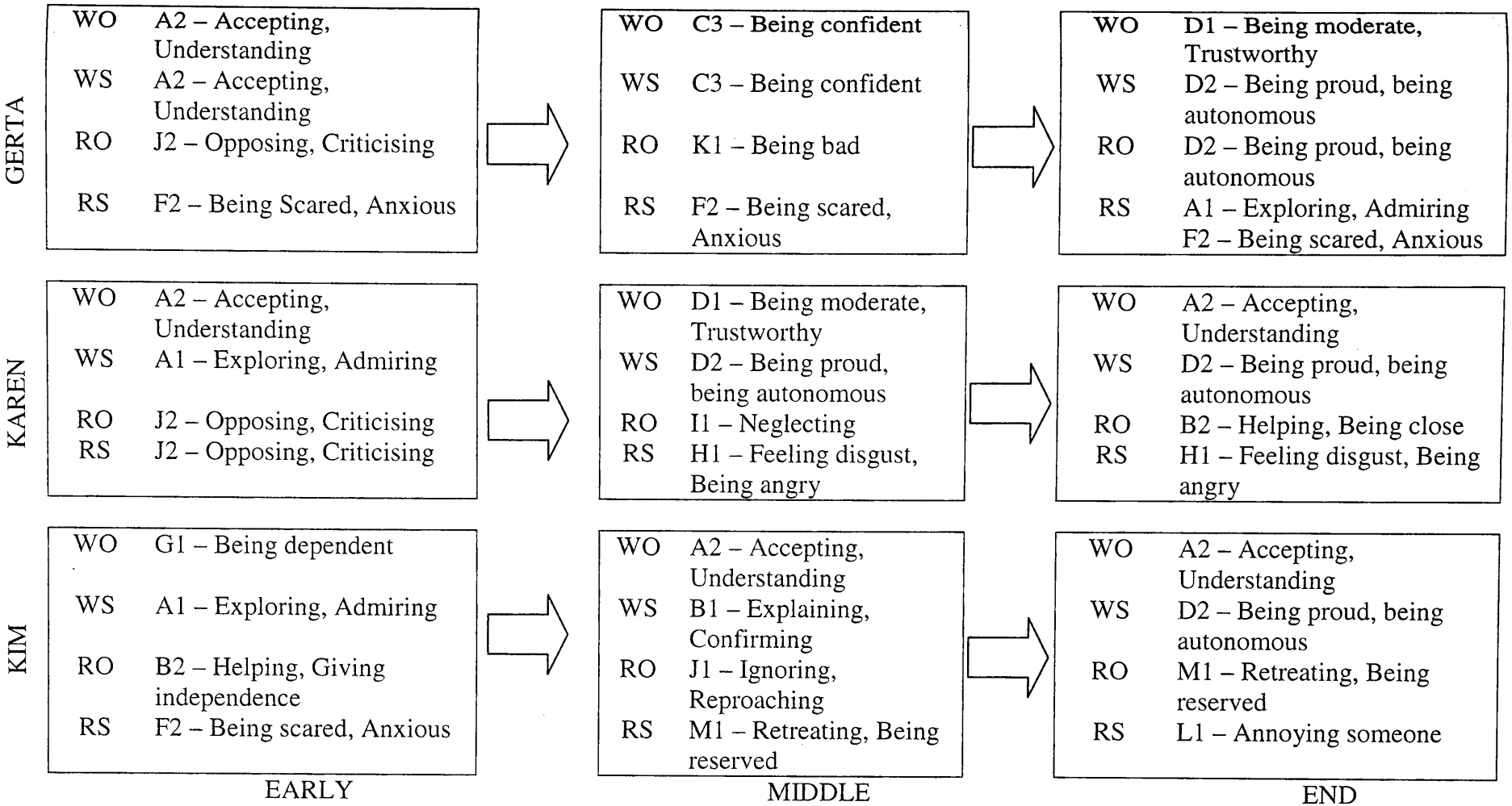


Figure 14 CCRT-LU formulations across entire therapy for patients Gerta, Karen and Kim

Patient Karen engaged in psychoanalytic treatment for three years. She was aged 34 years and was married with two children. She had been described as having features of Dependent personality disorder, within the neurotic personality organization (Matin, 2003). The GAF score rated her in the lower band of demonstrating some mild symptoms with some difficulty in social, occupational functioning as well as generally functioning pretty well. There was little change in her mastery scores from beginning to end phase of therapy. In relation to the other patients in this cohort, Karen's improvement was ranked as seventh, out of seventeen. Similar to the GAF and Mastery Scale scores, there was little change in the average RO transference valence from early (2.00) to late (2.29) stage of therapy; that is, a valence described as 'negative'. A shift occurred on the average RS transference valence from early (1.22) to late (2.57) phase of therapy; that is, a shift from 'mostly negative' to a mid-way point between 'negative' and 'positive'.

The CCRT-LU categories reflecting Karen's primary relational patterns are depicted in Figure 14. In the early phase of therapy, Karen's main wish was to be treated equally and to be self-accepting and independent. Her experience of others was of their opposition to her needs and their dominance. To which she would respond by becoming similarly oppositional. Her struggle in this relational pattern is exemplified in her account of an incident involving her mother criticising her for being a 'slob' and not one to 'take care of things'. The situation involved Karen experiencing her mother as trying to decide things for her; when she in fact wanted the freedom to choose for herself. Consequently, Karen rejected most things that represented her mother, in this instance it was a purse, but included traditional aspects of femineity. During the middle phase of therapy Karen's primary wish of others [WO] was for others to trusting

of her and she wanted to be self-determining. However, she continued to experience obstructions from others [RO], which at the time manifested as others ignoring her. Karen's was frustrated by this experience [RS]. By the end of therapy, Karen again expressed the wish for others [WO] to regard her as an equal. She continued to seek independence for herself [RS]. In the final phase, she experienced others as being close. Even though this is a positive theme, it does not necessarily qualify for a mostly positive valence rating, as the response of other was not entirely a satisfaction of her desires. She responded [RS] mostly with feelings of frustration and anger. Similarly, this negative theme does not automatically transpire into a negative valence rating. Her anger, depending on the manner of expression, may earn a positive valence as it works toward the satisfaction of her wishes. (The QUAINT item "Is protesting and recoiling" more aptly conveys this sentiment.) Overall, Karen showed little variation in the number of themes represented on each component for each phase of therapy. However, in the last phase of therapy two categories on the RO and three categories on the RS components, appeared in the Harmonious dimension. Karen's relational patterns at the end of therapy fell into two groupings: the relationship episodes involving her mother as the object and those involving other significant people, such as her husband and friends. Her relationship with her mother is epitomised by her comment "to keep my own sense of being I bitched about her a lot – if anything I bitch about her less now". This relational pattern carries some differences of intensity and insight, however it reads as being pervasive. On the other hand, Karen's experiences of her husband, for example, involved an overcoming of a pattern of disconnecting to be able to be close.

Kim, a 33-year-old single man, had been engaged in psychoanalytic treatment for a period of five years. The assessment of personality organization was in the realm

of borderline, which was characterised as more severe infusion of aggression on mental life and coincided with his being attributed with features of Antisocial personality disorder (Martin, 2003). At the beginning of therapy his GAF scores suggested moderate symptoms and moderate difficulty in a range of functioning domains. His Mastery Scale scores decreased across the three phases of therapy, indicating he experience less self-control and self-understanding. Kim's Mastery Scale score rankings placed him amongst the four least improved. The average early valence on the RO component was 'mostly negative' (1.3). This shifted to a mid-way position between 'negative-positive' (2.64) at the end of therapy. There was less of a change on the RS transference valence from the early (1.3, 'mostly negative) to the late (2.46, 'negative') phase of therapy.

Figure 14 presents Kim's primary CCRT formulations across all stages of therapy. Kim's mostly wanted others [WO] to need him; in particular he wanted women to desire him. And, he wanted to be like others whom he admired [WS] (this also manifested as wanting to be better than others). For example, Kim described a person he went to school with as being 'refined', 'immaculate' and 'groomed' and how he felt he had to compete with this person. He experienced others [RO] as being helpful; for example, he spoke of his mother and uncle offering him financial support and a friend who let him stay. However, this generosity from others elicited feelings of anxiety and weakness, such as "I'm afraid to . . . I'm afraid something would happen if I did [accept money]. . I'm afraid to do anything about it . . . I'm afraid of being alone, without anybody". During the mid phase of therapy, Kim wanted others [WO] to be more understanding of him, which corresponded with his need [WS] to be expressive. His interpersonal interactions became increasingly conflictual as he experienced others

[RO] ignoring him, dominating him and avoiding him. He coped with this through his own withdrawal [RS]. By the end of his psychoanalytic treatment Kim continued to want others to be considerate and he wanted to be self-determining. Others [RO] were avoiding him and he became the antagonist [RS]. This sequence of themes were especially manifest in relation to a girlfriend first refusing to sleep with him and then abusing him for not helping in an accident. He responded by rejecting her and accusing her of being stupid. The experience for Kim may not be read as being all bad, as suggested by an increased dispersal of RO themes, spreading across both dimensions, during the end stage of therapy. However, most of the scored themes were in the Disharmonious dimension revealing more of his defenses of attack and/or retreat and his projection of hostility and rejection of others toward him. Similarly, on the RS component eight categories were endorsed, the most frequent was L1-Annoying someone. Of these eight categories two were located in the Harmonious category.

3.3 Conclusion

The aim of this study was threefold: Firstly, to examine the CCRT patterns using indices of pervasiveness, valence and harmony. Secondly, to relate the CCRT patterns, based on the pervasiveness, valence and harmony indices, to clinical measures. Lastly, to illustrate the CCRT patterns of patients who have completed long term psychoanalysis. This study has demonstrated the CCRT-LU method as being a viable measure of relationship themes in patients undergoing psychoanalytic treatments.

- The calculation of 'Harmony' demonstrated the RS component as an indicator of greatest change over the course of therapy due to an increase of more positive or harmonious CCRT-LU categories by the end of therapy.

- The RS component on the valence index also demonstrated significant change over the course of therapy.

- The index of pervasiveness did not change significantly over therapy. However, patterns of variation on the pervasiveness index did predict change in symptoms and functioning.

- Based on the correlations between valence and harmony residual change scores and the Mastery Scale residual scores, the findings from this study indicate that changes in the CCRT RS component was related meaningfully to improvement.

- The CCRT-LU system clearly captured the relationship patterns of those individuals in psychoanalytic therapy. These patterns, illustrated at both the cluster and category levels, were observed to parallel the symptom changes.

Chapter 4

4.1 Overview of Discussion

The two studies contained within this thesis contribute to the ever-increasing body of psychoanalytic research. Specifically, this study is one of few projects to apply the CCRT method to a psychoanalytic data set. This study is the first to directly compare two related CCRT methodologies; as well as being an original investigation of the CCRT-LU patterns and change processes in a moderately sized sample of patient's engaged in psychoanalytic treatment. The following sections will discuss the findings of each study.

4.1.1 What are the characteristics of the QUAINT and CCRT-LU methodologies and what are the implications of each?

This study took verbatim conversations between therapists and patients that had been transcribed and subjected this raw data to three coding systems. It is recognised the application of a research-based coding system will impose meaning on the raw data. The extent to which the process of coding data distorts the inherent meaning in the therapeutic conversation is in part a topic of interest and has been addressed in this thesis. This research follows the assumption the tailor-made method closely follows the language and meaning of the therapist/patient exchange whereas the other two methods codes meaning into dictionary type systems. Thus in some ways this thesis addresses the validity of the coding systems with regards to their relationship with the raw data. Nevertheless it must be acknowledged any method that attempts to distil or extract meaning from therapeutic conversations will create a distortion. This is a limitation of this research methodology.

The interpersonal relationship patterns derived from the CCRT tailor-made method provided a clinical reference against which the relational patterns from the QUAINT and the CCRT-LU were contrasted. The strength of the tailor-made method is its proximity to the patient's narratives. "The CCRT focus is meant to represent the hub and the heart of the patient's character difficulties. It must be experienced by the core, repetitive, interpersonal concern that is linked to the reason that he or she is seeking treatment" (Book, 1998, p.17). It is important to acknowledge that the moment at which the data is subjected to the evaluation of the researcher or clinician, the patient's expression begins to be eroded. This observation does not assume to be problematic, in fact, this procedure is thought to parallel the clinician's task of selecting specifics of the patient's expressions: "The great volume of material brought to light in the course of a psychoanalytic treatment must be reduced to what is most important. Events are not significant in themselves, however: significance is given to them" (Albani et al., 2003, p.11). Albani and colleagues progress this thought by commenting on the import of being guided by conceptual models of therapeutic processes (Albani et al., 2003). Risks of misrepresenting the patient's expressions can be minimised by adherence to criteria for meaningfulness (Albani et al., 2003). In this study, the tailor-made method served as the benchmark to frame the translation into the QUAINT and CCRT-LU systems as well as the basis for the comparison of the two methods. The results found the CCRT-LU system produced CCRT patterns with greater similarity to the tailor-made CCRT formulations than those obtained using the QUAINT method. This finding substantiates the claim the CCRT-LU method maintains sensitivity to the patient's expressions made during therapy.

Using the weighted kappa method to establish agreement, results from the direct comparison of the QUAINT and CCRT-LU methods suggested a fair to moderate agreement, concluding negligible similarity between the two systems. The kappa values on the individual components demonstrate slightly less agreement on the Wish component than those obtained to the Response of Other and Response of Self components. This finding relates to the phenomenon of the patient's needs or wishes being less obviously articulated than the RO or RS components (Luborsky, 1998b) and therefore harder to identify. The CCRT-LU judge may be assisted by the surrounding material to infer the wish as in the tailor-made method (Luborsky, 1998b) whereas the QUAINT judge is isolated from the clinical context (Baranackie & Crits-Christoph, 1992). The agreement values derived from the entire data set were weaker than those found on two homogenous sub-groups, the most-improved cohort and least-improved cohort. The most-improved sub-sample obtained the highest agreement values that fell between .61 and .80, indicating 'substantial agreement' (Landis & Koch, 1977). The agreement values for the least-improved sub-sample fell mid-way between those values obtained for the entire data set and those in the most-improved cohort. These higher agreement values may suggest the judge's established greater agreement for those patients at the extremes of health; either greater well-being or severe psychological disturbance. However, the discrepancies between the agreement values on the three cohorts (total patients, most-improved & least-improved) may be attributed to additional factors relating to the judges, patient characteristics as well as treatment processes. Conservatively, these finding suggest the systems are appraising the therapeutic phenomenon through related, albeit different lenses.

The methodological structure of the CCRT-LU system permits the judge to appraise the interpersonal narrative within context of the therapy session. This allows the judge to become familiar with the nuances of the patient's expression thereby supporting the judge's identification of the components of relational patterns. The hierarchical structure of the CCRT-LU system together with the object- and subject-directed dimensions facilitates an interactive process of articulating the thematic content of each relationship episode. Furthermore, the inclusion of the object- and subject directed dimension provides detail to the concordance or discordance of themes as experienced by the patient in relation to others and self. That is, the division of the 'response of self' component, for example, into "I do (. . .) to the other" [RSO] and "I do (. . .) to me" [RSS] will capture different aspects of the patient's intrapsychic processes (Albani et al., 2003). For example, this aspect of the CCRT-LU system can reflect both the angry feelings or behaviour directed toward an other [RSO-H1], as well as conveying their associated feelings of fear or regret [RSS-F1]. Albani and colleagues have previously made this observation (Albani et al., 2002). The methodological structure of the CCRT-LU system offers a plasticity of structure, which approximates the 'art form' psychoanalysis without apparent compromise to empirical integrity. The hierarchical structure also allows the researcher to choose a level or tier, at which to analyse the data. For example, Albani et al. (2003) evaluated their data at the sub-category level yet analysed the data at the cluster level (refer to Table 5). Similarly, in this study the data was judged at the sub-category level, however the categories (mid-level) were use to compare with the QUAINT items.

The CCRT-LU coding system was found to be comprehensive given the available predicate list of 119 sub-categories grouped as 30 mid-level categories and 13

clusters; thereby providing a larger dictionary of themes. Two anomalies were noted in the use of this coding system: (1) themes of assertiveness are embedded in the disharmonious dimension cluster K22 "dominating, asserting, repressing . . . " and (2) themes of withdrawing are implicitly negative given they are located with the disharmonious dimension. Observations that the M cluster can be interpreted from both the harmonious and disharmonious (Dan Pokorny, personal communication, June 2003) informed some parts of the analyses contained within the second study. The analysis found the exclusion of the M cluster did not alter the results.

Alternatively, the QUAINT system was designed to distance the judge from the clinical context in order to achieve empirical rigor by minimising bias (Baranackie & Crits-Christoph, 1992; Crits-Christoph et al., 1994). Nevertheless, the methodological structure of the QUAINT permits the judge to consider the degree to which an item is evident in a particular relationship episode; therefore allowing the judge to cogitate on the patients' expression before executing a translation into the QUAINT items. This process draws on amongst other things, the judges' clinical aptitude. A significant strength of the QUAINT systems is its basis in a nomothetic method; that is, the items, or standard categories, were derived from a theory of interpersonal behaviour [Benjamin's SASB] (Baranackie & Crits-Christoph, 1992; Crits-Christoph, 1998). However, as with many coding systems some categories are noticeably absent. For example, the QUAINT code lacks items that explicitly capture patients' themes of sexuality, including sexual intimacy, sexual satisfactions or sexual frustrations. Therefore one is forced to find a fit in one of the available items such as '*Is joyfully connecting*' or '*Feels loving*' or '*Is walling off and distancing*'. It could be argued these categories represent an essence of the motivated behaviour; for example, the concept of

'joyfully connecting' does convey an element of intimacy. However, the concern resides in the lack of discrimination of patient's intimate experiences.

4.1.2 To what extent are CCRT patterns modifiable? What are the relational patterns of patients receiving long-term psychoanalysis and how do they relate to outcome measures?

Indices of valence, pervasiveness and harmony were adopted to examine the changes in patients interpersonal relationship themes. These indices were also correlated with several clinical outcome measures to investigate outcome. Results from the investigation of patient's CCRT patterns consistently demonstrated the sensitivity of the RS component to reflect change processes. This was evident by the emergence of more positive themes across the three phases of therapy, as expressed by the harmony calculation as well as by the non-interference with the wish satisfaction as indicated by the change in valence. Together with the findings of a significant correlation between the change in RS valence and the change in mastery scores, these results are commensurate with previous observations that mastery of self-control and self-understanding as reflected in the RS component, contributes to clinical improvement (Grenyer, 2002). The trend of change on the RO harmony calculation paralleled the trend on the RS component, however statistical significance was not achieved on the RO component. The changes noted from early to late therapy on the RO component might suggest some mastery had been achieved in similar manner as evident on the RS component. However, the strength of the findings may have been compromised by the more severely disturbed patients' perceptions of others (Leising, Rudolf et al. 2003). Minimally, what is apparent from this study is that the RO component changed, but less than that observed on the RS component which suggests the patients felt better about themselves and/or were less affected by other's responses.

In this study the index of pervasiveness did not conform to the theoretical principles that maladaptive relationship themes will become less pervasive over the course of therapy (Crits-Christoph & Luborsky, 1998). That is, in this study there was little change in pervasiveness as indicated by the number of relational themes, from early to late therapy. However, the pervasiveness index was found to be an important variable, along with mastery scores in determining improvement. The findings from this study conclude the relationship themes became more positive and harmonious; however there was little change in the variety of relationship patterns.

Improvements in transference valence and mastery typically manifest as gains in experience of well-being (Grenyer, 2002) and the GAF, HSRS and SSI are established clinical measures (Luborsky et al., 1993; Piersma & Boes, 1997). However, only small changes in valence were observed across the course of therapy in the whole sample; and there was a lack of significant correlations between the valence and most of the clinical measures. The exception was the significant correlation between the mastery scale scores and the RS-valence change score, which gives further validation to the qualities of both the mastery scale and RS component. The significant relationship between the RS-harmony component and the composite index of clinical improvement (S.S.I.) also suggest the strength of the RS component to reflect therapeutic gains. The RO- and RS-harmony components correlated significantly with the mastery scale residual change scores. Conversely, the limited variation on the RO component, especially as demonstrated by the absence of significant relationships between the RO-valence and the clinical scales, may suggest the maintenance of established perception of others' responses. The trend of change on the RO-harmony component parallelled that of the RS component, albeit without significant change.

The CCRT-LU system characterised this patient population as those who have experienced chronic interpersonal conflict and emotional disturbance. At the CCRT-LU's dimensional level the relational patterns comprised of high frequencies on the Harmonious wish categories and high frequencies on the Disharmonious response of other and response of self categories, across all phases of therapy. The lack of an inversion of this profile, that is a complete shift in high frequency to the Harmonious categories late in treatment, is in accordance with previous observations that conflicts do not entirely abate (Crtis-Christoph & Luborsky, 1998) and that the theoretical position that people's transference does not substantially change (Luborsky, 1998d).

Results from the CCRT-LU cluster level of analysis found patients mostly wanted others [WO] to be attentive [cluster A] and close [cluster C]. For themselves, they wished [WS] to be self-determined [cluster D] and to be close [cluster C]. Only slight fluctuations of frequency on the WO and WS components were noted across the phases of therapy. This finding is congruent with previous observations of the stability of the Wish component (Crits-Christoph & Luborsky, 1998). Furthermore and as shown in other studies (e.g. Albani et al. 2002; Albani et al. 2003), this study illustrated the capacity of the CCRT-LU system to reflect the patient's wish themes as being both concurrent and conflictual. Albaini and colleagues (2003) questioned the meaning of conflict in this methodological context, as it is divergent from the analytic concept of conflict. This is one aspect of CCRT theory requiring consideration (Horst Kächele, personal communication, September 2004). The distribution of clusters on the RO component spread across all 13 clusters, however the most frequently occurring was cluster J [Rejecting], followed by cluster K[Subjugating], and with a noticeable peak in frequency on cluster C[Loving, Feeling Well] in the final phase of therapy. That is,

patients mostly experienced the other as rejecting and controlling during all phases of therapy however less frequently by the end of therapy. The spread of clusters on the RS component suggested the predominance of negative reactions in interpersonal interactions, particularly clusters F[Being dissatisfied, Being scared], G[Being determined by others] and H[Being angry, Unlikable]. Nevertheless, significant changes between early and late phase of therapy were observed, especially with regards to the increase in the harmony of RS component themes, especially clusters A[Attending to], C[Loving, Feeling well] and D[Being self-determined].

The finding that particular clusters or categories concentrate in high frequencies across interpersonal narratives parallels with Albani and colleagues understanding that not all categories will be equally represented on all components [e.g. WO, WS, RO & RS] (2002). For example, clusters H [Being angry, Unlikeable], J [Rejecting] and K [Subjugating] were the main themes on the RO component. Similarly, the clusters on the RS component congregated on the disharmonious clusters F[Being dissatisfied], G[Being Determined by Others] and H[Being Angry, Unlikable]. Such trends of CCRT formulations is not incongruous with theoretical principles and clinical observations such as those of Grande and colleagues:

> "In the successful course of an analytic process a patient's central conflicts are not neutralised; it would be more accurate to say that they are constructively modified and better integrated in the important spheres of life. Nor does the central problematic relationship become "diminished" in the course of successful therapy; what happens instead is that it loses more and more of its

> compulsive character, involves less subjective suffering for the patient, and is recast in qualitative terms" (Grande, Rudolf, Oberbracht, Jakobsen & Keller, 2004, p.45).

Examination of the relational patterns of the three patients who demonstrated varying degrees of improvement illustrates some aspects of what Grande and colleagues describe. Gerta's improvement, for example, was evidenced by a dispersion of relational themes, especially a shift from the disharmonious dimension to the harmonious dimension on the RS component, rather than a dramatic change of relational themes. This case example supports previous findings and the theoretical positions that a move away from a single pervasive relationship theme toward multiple relationship themes is suggestive of improvement. This engages the debate on the singularity or multiplicity of interpersonal relationship themes and relates to observations that a shift toward multiple themes corresponds to less psychopathology (Crits-Christoph et al., 1994; Crit-Christoph, 1998).

4.2 Limitations

Limitations relating to the first study included the modifications made to the data produced from the respective CCRT methodologies in order to facilitate a comparison of methods. Specifically, the CCT-LU data lost some components of directional dimensions as comparisons were only made using the W, RO and RS components. Furthermore, due to low numbers of RE's for some patients single high frequency of themes on individual components were not discernable due to an even distribution of themes; therefore the selected themes were not necessarily the most frequent theme. The selection guidelines were applied to 26% of all components (N=141). With reference to the QUAINT system, the modifications included the

selection of a single theme per component in spite of the multiple themes produced in the profile analysis. During the procedure of preparing the QUAINT data for comparison with the CCRT-LU data, the selection of relational themes from the QUAINT cluster analysis was a difficult choice when the coefficients were the same and the clusters contained diverse themes. This occurred in 5% of the total number of components per patient, per phase of therapy (N=141) and occurred when the profile analysis was performed on small samples of relationship episodes for the particular phase of therapy, this was especially the case in the middle sessions. For this proportion of components, the QUAINT system may have been misrepresented due to the lack of statistical rationale for the selected items. The chosen items therefore were selected on the basis of clinical judgement. In short, the decision pathways adopted to make the systems comparable risked misrepresentation of the performance of each method.

The small sample size restricted the generation of interpersonal narratives, especially at the mid- and end-phases of therapy. This subsequently contributed to a lack of statistical power. The absence of self-report measures and the variation in psychoanalytic treatment procedures also placed limitations on the findings, as did the reliance on clinician rated clinical measures that were applied retrospectively by experienced clinicians; however not necessarily by the treating clinician.

4.3 Conclusions and Contributions

The intention of this study was to investigate two related CCRT methodologies and based on the findings select one methodological system to examine the relational patterns of patients who had received long term psychoanalysis. In doing this, the study demonstrated the applicability of the CCRT methodologies to psychoanalytic research;

contributed to the development of CCRT methodological processes; and illustrated the interpersonal relationship patterns of patients in long-term psychoanalytic therapy.

The data set consisted of interpersonal narratives derived from seventeen patients who had been engaged in psychoanalytic treatment for two- to six years, attending three- to five-sessions per week. The patients were a heterogeneous sample of men and women; of a variety of ranges; mostly heterosexual however two were homosexual; most resided in the United States of America, two were from European countries; some were students, others were professionals and several were self-employed. This patient cohort also exhibited a range of features of personality disorders such as dependent, avoidant, obsessive-compulsive and borderline. All struggled in their relationships, particularly with parents, partners and siblings.

The hypothesis the two CCRT methodologies will reflect similar relational patterns, was supported. Both the QUAINT and CCRT-LU systems demonstrated their capacity to capture the patients core relational themes and reflect changes over the course of long-term psychoanalysis. However, the analysis demonstrated the CCRT-LU system as being closer to the tailor-made expression. The CCRT-LU method was found, in general, to be more sensitive to clinical material and therefore the preferred system of these process-oriented methodologies. When compared, the QUAINT and the CCRT-LU systems produced CCRT patterns that were modestly comparable. This finding may be attributable to the method devised to facilitate the comparison; however, it is difficult to discern the extent to which both systems were distorted by the study's design. The fact it was applied consistently across the entire sample and discrepancies occurred in different cohorts suggests other factors, such as characteristics of the therapeutic sample, either as the patients or the psychoanalytic treatment, or both.

These results may in fact suggest the two CCRT systems are differently sensitive. That is, the QUAINT method captures the CCRT formulations of the neurotic and less severe patients but does not capture the CCRT patterns of the more severe or borderline organised personality, as well as the CCRT-LU system.

This study of interpersonal relationship themes, using the CCRT-LU system, revealed variations in relational patterns across the phases of psychoanalytic psychotherapy. These variations were most noticeable on the RS component for valence and harmony, especially toward the last phase of therapy, and that they correlate well with measures of mastery. The changes on the valence RO component were clinically meaningful; however they were not found to be statistically significant. Moreover, the harmony RS component suggested harmonious changes in relationship themes relate to indicators of improvement, specifically in this study the composite index of success, satisfaction and improvement. The valence index performed in accordance with previous studies; that is, valence maintained a pattern of predominant negative responses with significant changes concentrating on the RS component (Albani et al., 1999; Grenyer & Luborsky, 1998). The pervasiveness index was demonstrated as an important variable in relating to clinical outcome measures in spite of its failure to conform with expected change over time.

Further research will help identify the patterns and meaning of change within different diagnostic cohorts. Future investigations of therapeutic process using the CCRT methodologies in tandem with other, perhaps yet to be developed, research tools are required to further elucidate the changes experienced by patients. In the meantime, this study supports the use of the CCRT-LU system in research contexts. Moreover, given the allegiance to the family of CCRT methodologies, which have already

demonstrated clinical applications (e.g. Albani et al., 2003; Book, 1998), the CCRT-LU may also be applied to clinical settings to support the practice of psychoanalytic therapy and to progress psychodynamic psychotherapy theory.

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Appendix A

QUAINT Score Sheets

QUAINT JUDGING JUDGE: _____ DATE: _____

		RE CODE NUMBER									
	WISHES										
1	To be freeing and forgetting										
2	Other to freeing and forgetting me										
3	To be affirming and understanding										
4	Other to be affirming and understanding me										
5	To be loving and approaching										
6	Other to be loving and approaching me										
7	To be nurturing and protecting										
8	Other to be nurturing and protecting me										
9	To be watching and controlling										
11	Other to be watching and controlling me										
11	To be belittling and blaming										
12	Other to be belittling and blaming me										
13	To be attacking and rejecting										
14	Other to be attacking and rejecting me										
15	To be ignoring and neglecting										
16	Other to be ignoring and neglecting me										
17	To be asserting and separating										
18	Other to be asserting and separating from me										
19	To be disclosing and expressing										
20	Other to be disclosing and expressing me										
21	To be joyfully connecting										
22	Other to be joyfully connecting with me										
23	To be trusting and relying										
24	Other to be trusting and relying on me										
25	To be deferring and submitting										
26	Other to be deferring and submitting to me										
27	To be sulking and scurrying										
28	Other to be sulking and scurrying from me										
20	To be protesting and recoiling										
30	Other to be protesting and recoiling from me										
31	To be walling off and distancing										
32	Other to be walling off and distancing from me										

1----------2----------3----------4----------5

not present — moderately present — strongly present

QUAINT JUDGING JUDGE: DATE:

	RESPONSE OF OTHER	RE CODE NUMBER									
1	Is freeing and forgetting										
2	Is affirming and understanding										
3	Is loving and approaching										
4	Is nurturing and protecting										
5	Is watching and controlling										
6	Is belittling and blaming										
7	Is attacking and rejecting										
8	Is ignoring and neglecting										
9	Is asserting and separating										
10	Is disclosing and expressing										
11	Is joyfully connecting										
12	Is trusting and relying										
13	Is deferring and submitting										
14	Is sulking and scurrying										
15	Is protesting and recoiling										
16	Is walling off and distancing										
17	Feels permissive and freeing										
18	Feels friendly										
19	Feels loving										
20	Feels interested										
21	Feels powerful										
22	Feels annoyed and irritated										
23	Feels hostile and angry										
24	Feels apathetic										
25	Feels liberated and independent										
26	Feels excited										
27	Feels joy and loved										
28	Feels trusting and hopeful										
29	Feels constrained and helpless										
30	Feels fear										
31	Feels disgusted										
32	Feels sad										

1----------2----------3----------4----------5

not present — moderately present — strongly present

QUAINT JUDGING JUDGE: _____ DATE: _____

		RE CODE NUMBER									
	RESPONSE OF SELF										
1	Is freeing and forgetting										
2	Is affirming and understanding										
3	Is loving and approaching										
4	Is nurturing and protecting										
5	Is watching and controlling										
6	Is belittling and blaming										
7	Is attacking and rejecting										
8	Is ignoring and neglecting										
9	Is asserting and separating										
10	Is disclosing and expressing										
11	Is joyfully connecting										
12	Is trusting and relying										
13	Is deferring and submitting										
14	Is sulking and scurrying										
15	Is protesting and recoiling										
16	Is walling off and distancing										
17	Feels permissive and freeing										
18	Feels friendly										
19	Feels loving										
20	Feels interested										
21	Feels powerful										
22	Feels annoyed and irritated										
23	Feels hostile and angry										
24	Feels apathetic										
25	Feels liberated and independent										
26	Feels excited										
27	Feels joy and loved										
28	Feels trusting and hopeful										
29	Feels constrained and helpless										
30	Feels fear										
31	Feels disgusted										
32	Feels sad										
33	Is self accepting and exploring										
34	Is self loving and cherishing										
35	Is self nourishing and enhancing										
36	Is self monitoring and restraining										
37	Is self indicting and oppressing and guilty										
38	Is self rejecting and destroying										
39	Is daydreaming and neglecting										
40	Is spontaneous										

Appendix B

Predicates of the Reformulated CCRT Category System [CCRT-LU] & CCRT-LU Score Sheets

The CCRT-LU System[1]

	CLUSTERS	CATEGORIES	SUB-CATEGORIES
I. harmonious	*A. Attending to*	**A1. exploring, admiring**	A11 being curious, being interested, exploring, being active, being motivated, being open A12 sorting oneself out, searching, standing up for something A13 considering capable A14 admiring, being impressed A15 being enthusiastic, being fascinated A16 identifying oneself, being like the other
		A2. accepting, understanding	A21 accepting, respecting, taking seriously A22 giving independence, being attentive, leaving in peace A23 approaching, noticing, showing interest, listening, excusing A24 perceiving feelings, accepting feelings, being sensitive A25 pitying, being touched, being stirred A26 understanding A27 forgiving, reconciling
	B. Supporting	**B1. explaining, confirming**	B11 explaining, communicating, stating, expressing, convincing B12 standing by someone, praising, agreeing, inspiring, encouraging
		B2. helping, giving independence	B21 protecting B22 being generous, spoiling, preferring B23 helping, standing up for someone
	C. Loving, Feeling Well	**C1. being close**	C11 being close, accepting, being intimate, providing for, being good, being loving C12 consoling, comforting C13 liking, being liked, being likeable, having friends, getting along
		C2. loving, having relationship	C21 falling in love, being attractive C22 loving C23 having children, having a relationship
		C3. being confident, satisfied, experiencing pleasure	C31 trusting, being certain, believing, being confident, being secure C32 being relieved C33 letting oneself go, being spontaneous, having scope to develop, being happy, feeling well, enjoying, having fun C34 being glad, being (happily) surprised, being satisfied
		C4. being sexually active,interested	C41 being romantic C42 making a pass, flirting C43 touching, kissing, cuddling, being affectionate C44 desiring, being aroused, wanting, being sexually attractive C45 having sex, being instinctual, being potent, being passionate, being sexually experienced
		C5. being healthy, living	C51 being healthy C52 living
	D. Being Self-Determined	**D1. being moderate (out of strength), trustworthy**	D11 being thankful D12 being tolerant, being willing to compromise D13 being considerate, being polite, being moderate, being modest D14 being calm, being patient D15 bearing, enduring, standing, coping D16 being trustworthy, being honest, being reliable, being faithful, treating fairly, being correct D17 being sensible, being constructive D18 having responsibility
		D2. being proud, being autonomous	D21 being strong, being superior, being important, being courageous, deciding D22 being capable, being experienced, being successful, being proud D23 being ambitious, being conscientious D24 being a role-model, being perfect D25 being independent, being self-sufficient D26 being sure of oneself, having trust in oneself, being self-confident D27 having self control, being thoughtful, being skeptical, being self-critical D28 changing, developing, improving

[1] *Version March 2001 © C. Albani, D. Pokorny, G. Blaser, S. Grueninger, Leipzig – Ulm 2001; English translation R. Deighton, U. Jacobs, C. Fi*
Ulm – Berkeley – Leipzig 2001

II. disharmonious

CLUSTERS	CATEGORIES	SUB-CATEGORIES
E. Being Depressed, Resigning to sth.	E1. being disappointed	E11 being unhappy, being depressed, being disappointed E12 despairing, suffering, grieving
	E2. resigning oneself to something	E21 giving up, resigning E22 being indifferent, being bored, being apathetic, being sluggish
F. Being Dissatisfied, Being Scared	F1. feeling guilty, ashamed, being dissatisfied	F11 feeling guilty, regretting F12 shaming oneself F13 feeling unwell, feeling dissatisfied F14 feeling frustrated
	F2. being scared, anxious	F21 being anxious, being scared, being worried, avoiding, being cowardly F22 being unsure, being confused, being indecisive F23 being nervous, being hysterical, being tense, being unrestrained F24 being shocked, being outraged, feeling caught in the act
G. Being Determined by Others	G1. being dependent	G11 being alone, missing someone, being lonely G12 being dependent, clinging G13 not being self-sufficient, being self-insecure G14 being passive, doubting, persisting, stagnating, worsening
	G2. being weak	G21 being weak, being helpless, being without rights, being exposed, being unprotected, being inferior, being injured G22 being incapable, being inexperienced G23 disappointing someone, being overstrained, failing G24 being low, being unimportant, being restrained, being ugly G25 being moderate (out of weakness)
H. Being Angry, Unlikable	H1. feeling disgust, being angry	H11 feeling disgust H12 feeling contempt H13 being jealous, being envious H14 being hurt, being offended H15 not liking H16 being angry, being enraged, being frustrated by something H17 hating
	H2. being disliked	H21 being resentful, being impatient H22 being stingy H23 being unlikable, being disliked, being uninteresting H24 being unfriendly, being unthankful, being impolite
I. Being Unreliable	I1. neglecting	I11 being insensitive, having no understanding, being destructive, being foolish, being uncontrolled I12 neglecting, abandoning, being superficial, being irresponsible, being heartless, being lazy
	I2. being selfish	I21 being self-satisfied, being uncritical I22 being dishonest, being unfair I23 being egoistical, being selfish, being greedy
J. Rejecting	J1. ignoring, reproaching	J11 unnerving, disheartening, undermining, being disinterested, ignoring J12 blaming, reproaching, accusing
	J2. opposing, criticizing	J21 opposing, competing, being stubborn, disputing J22 declining, excluding, criticizing, admonishing, rejecting, judging, rebuke
K. Subjugating	K1. being bad	K11 being bad, exploiting, cheating, betraying, denying, stealing K12 ingratiating, intriguing, deceiving
	K2. dominating	K21 committing, prescribing, influencing, pressurizing, demanding, forcing to do something K22 dominating, asserting, repressing, debasing, subjugating, disadvantaging, controlling, test someone, being strict
L. Annoying, Attacking	L1. annoying someone	L11 hurting, offending, embarrassing, making ridiculous, humiliating L12 being malicious, being cynical, laughing at someone L13 annoying, harassing, inhibiting, bothering someone L14 disturbing, distracting
	L2. attacking	L21 scaring, threatening, attacking, provoking L22 tormenting, injuring, hostile, breaking L23 punishing, taking revenge, destroying, being violent L24 abusing, raping
M. Withdrawing	M1. retreating, being reserved	M11 leaving, distancing, demarcating M12 keeping one's distance, retreating, withdrawing M13 being distrustful M14 avoiding conflict, being conforming, being complaisant, giving in, being submissive M15 being withdrawn, keeping quiet M16 being reserved, being shy M17 being compulsive M18 having no children, not having a relationship
	M2. being sexually inactive	M21 being disinclined, being acquiescent M22 being inhibited, not being aroused, being impotent M23 being sexually inexperienced
	M3. being ill	M31 being exhausted, being tired M32 having symptoms M33 being physically ill, being mentally ill M34 dying, killing oneself

CCRT-LU SCORESHEET

Date: Judge/Scorer:
Patient #: Session #: # of RE's: Page:

RE #	Thought Unit/Tailor-made Method	Dimension of CCRT-LU Category System

Table 2. Dimensions of the CCRT-LU Category System

W				R			
WO "The other should (...)."		WS "I want to (...)."		RO "The other does (...)."		RS "I do (...)."	
WOO	**WOS**	**WSO**	**WSS**	**ROO**	**ROS**	**RSO**	**RSS**
"The other should (...) to him/herself or other."	"The other should (...) to me."	"I want to do (...) to the other."	"I want to do (...) to me."	"The other does (...) to him/herself or other."	"The other does (...) to me."	"I do (...) to the other."	"I do (...) to me."

Note: W = wishes; R = responses; O = other; S = self.
(Albani, Pokorny, Blaser, Gruninger, Konig, Marschlke, Geissler, Koerner, Geyer & Kachele, 2002, p. 327)

Pt #: RE #: Position: RE Object: Session #:

WOO	WOS	WSO	WSS	ROO	ROS	RSO	RSS
W		RO			RS		

Pt #: RE #: Position: RE Object: Session #:

WOO	WOS	WSO	WSS	ROO	ROS	RSO	RSS
W		RO			RS		

Pt #: RE #: Position: RE Object: Session #:

WOO	WOS	WSO	WSS	ROO	ROS	RSO	RSS
W		RO			RS		

Pt #: RE #: Position: RE Object: Session #:

WOO	WOS	WSO	WSS	ROO	ROS	RSO	RSS
W		RO			RS		

Pt #: RE #: Position: RE Object: Session #:

WOO	WOS	WSO	WSS	ROO	ROS	RSO	RSS
W		RO			RS		

Appendix C

SPSS Syntax for Profile Analysis of QUAINT Scored Data

Example of the SPSS syntax for profile analysis of QUAINT scored data for patient #5 in the early phase of therapy (position 1):

```
USE ALL.
COMPUTE filter_$=((patient = 5 & position = 1)).
VARIABLE LABEL filter_$ '(patient = 5 & position = 1)'.
VALUE LABELS filter_$ 0 'Not Selected' 1 'Selected'.
FORMAT filter_$ (f1.0).
FILTER BY filter_$.
EXECUTE.

flip variable=
wfree,wofree,waffirm,woaffirm,wloving,woloving,wnurture,wonurtur,wwatch,wowatch,wbelittl,w
obelitt,wattack,woattack,wignore,woignore,wassert,woassert,wdisclos,wodisclo,wjoy,
wojoy,wtrust,wotrust,wdefer,wodefer,wsulk,wosulk,wprotest,woprotes,wwall,wowall.

flip variable=
rofree,roaffirm,rolove,ronurtur,rowatch,robelitt,roattack,roignore,roassert,rodisclo,rojoy,rotrust,r
odefer,rosulk,roprotest,rowall,rofperm,roffrien,roflove,rofinter,rofpower,rofannoy,rofhosti,rofapat
h,rofliber,rofexcit,rofjoy,roftrust,rofconst,roffear,rofdisgu,rofsad.

flip variable=
rsfree,rsaffirm,rslove,rsnurtur,rswatch,rsbelitt,rsattack,rsignore,rsassert,rsdisclo,rsjoy,rstrust,rs
dfer,rssulk,rsprotes,rswall,rsfperm,rsffrien,rsfinter,rsfpower,rsfannoy,rsfhosti,rsfapath,rsfliber,rsf
excit,rsfjoy,rsftrust,rsfconst,rsffear,rsfdisg,rsfsad,isaccept,isloving,isnouris,ismonit,isindict,isreje
ct,isdaydre,issponta.

CLUSTER  var001 var002 var003 var004 var005 var006 var007 var008 var009 var010
/METHOD BAVERAGE
/MEASURE=CORRELATION
/ID=case_lbl
/PRINT SCHEDULE
/PLOT DENDROGRAM VICICLE.
```

Example of SPSS syntax for profile analysis of QUAINT scored data for patient #5 in the late phase of therapy (position 3):

```
USE ALL.
COMPUTE filter_$=((patient = 5 & position = 3)).
VARIABLE LABEL filter_$ '(patient = 5 & position = 3)'.
VALUE LABELS filter_$ 0 'Not Selected' 1 'Selected'.
FORMAT filter_$ (f1.0).
FILTER BY filter_$.
EXECUTE.
```

```
flip variable=
wfree,wofree,waffirm,woaffirm,wloving,woloving,wnurture,wonurtur,wwatch,wowatch,wbelittl,w
obelitt,wattack,woattack,wignore,woignore,wassert,woassert,wdisclos,wodisclo,wjoy,
wojoy,wtrust,wotrust,wdefer,wodefer,wsulk,wosulk,wprotest,woprotes,wwall,wowall.

flip variable=
rofree,roaffirm,rolove,ronurtur,rowatch,robelitt,roattack,roignore,roassert,rodisclo,rojoy,rotrust,r
odefer,rosulk,roprotest,rowall,rofperm,roffrien,roflove,rofinter,rofpower,rofannoy,rofhosti,rofapat
h,rofliber,rofexcit,rofjoy,roftrust,rofconst,roffear,rofdisgu,rofsad.

flip variable=
rsfree,rsaffirm,rslove,rsnurtur,rswatch,rsbelitt,rsattack,rsignore,rsassert,rsdisclo,rsjoy,rstrust,rs
dfer,rssulk,rsprotes,rswall,rsfperm,rsffrien,rsfinter,rsfpower,rsfannoy,rsfhosti,rsfapath,rsfliber,rsf
excit,rsfjoy,rsftrust,rsfconst,rsffear,rsfdisg,rsfsad,isaccept,isloving,isnouris,ismonit,isindict,isreje
ct,isdaydre,issponta.

CLUSTER  var001 var002 var003 var004 var005 var006
/METHOD BAVERAGE
/MEASURE=CORRELATION
/ID=case_lbl
/PRINT SCHEDULE
/PLOT DENDROGRAM VICICLE.
```

Appendix D

Similarity Rating Score Sheets and CCRT Formulations

PATIENT #	QUAINT vs CCRT-LU [0 -100]		
	W	RO	RS
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			

PATIENT #	CCRT-LU vs Tailor-Made [0 -100]		
	W	RO	RS
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			

PATIENT #	QUAINT vs Tailor-Made [0 -100]		
	W	RO	RS
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			

Table 1 Early phase of therapy tailor-made primary CCRT formulations for all patients

	EARLY PHASE OF THERAPY		
Patient	**WISH**	**RESPONSE OF OTHER**	**RESPONSE OF SELF**
1 Quin	To be treated respectfully.	Accuses of being ridiculous	I don't understand.
2 Gerta	To please …	Gets mad & huffy, doesn't notice me	I mess things up.
3 Sally	To be independent.	Are against me	At a standstill & feels resentful.
4 Artie	To be close.	There is nobody there	Yearning. Afraid.
5 Quoit	To be free.	Argue.	I get furious.
6 Carla	To be cared for.	Is insensitive	Feels afraid & resentful.
7 Amal	To be self-confident.	Are judgemental	Feels weak & insecure.
8 Troy	To make a good impression.	Are restraining	Gets frustrated.
9 Karen	To be equal & to be accepted.	Is rejecting	I get enraged. Feel scared.
10 Ken	To be self-sufficient.	They don't understand.	Get upset.
11 Kim	To be like others. Not to be different.	Are accomplished & sophisticated.	Feels angry & helpless.
12 Leah	To be strong in a relationship.	Is emotionally controlling.	I don't know what to do. Am afraid.
13 Tara	To be free to express.	Is unlikeable. Rejects me.	I get fed-up. Withdraws.
14 Wyn	To be powerful	Is controlling & criticising	Is angry & afraid
15Victor	To influence the other.	Others disregard me.	Feels resentful & furious
16 Sue	To have security	Expose me & devalue me.	Feels worthless & humiliated.
17 Kris	To enjoy one another's company.	Aren't interested and are abusive.	Becomes antagonistic. Hurt. Angry.

Table 2 Early phase of therapy 'primary' QUAINT formulations for all patients

	EARLY PHASE OF THERAPY		
nt	WISH	RESPONSE OF OTHER	RESPONSE OF SELF
	To be trusting & relying [23] and To be walling off & distancing [31]	Is watching & controlling [5] and Is belittling & blaming [6]	Is ignoring & neglecting [8] and Is self-rejecting & destroying [38]
a	Other to be affirming & understanding me [4] and To be disclosing & expressing [19]	Is nurturing & protecting [4] and Is ignoring & neglecting [8]	Is deferring & submitting [13] and Feels fear [30]
	To be joyfully connecting [21] and Other to be joyfully connecting with me [22]	Is watching & controlling [5] and Feels interested [20]	Feels constrained & helpless [29] and Feels sad [32]
e	To be affirming & understanding [3] and Other to be nurturing & protecting me [8]	Is belittling & blaming [6] and Is ignoring & neglecting [8]	Feels powerful [21] and Feels constrained & helpless [29]
nt	To be joyfully connecting [21] and Other to be joyfully connecting with me [22]	Is affirming & understanding [2] and Feels hostile & angry [23]	Is attacking & rejecting [7] and Is self-monitoring & restraining [36]
a	To be asserting & separating [17] and To be protesting & recoiling [29]	Is sulking & scurrying [14] and Feels hostile & angry [23]	Is protesting & recoiling [15] and Feels hostile & angry [23]
l	To be attacking & rejecting [13] and To be asserting & separating [17]	Is ignoring & neglecting [8] and Is protesting & recoiling [15]	Is walling off & distancing [16] and Feels annoyed & irritated [22]
	Other to be affirming & understanding me [4] and Other to be nurturing & protecting me [8]	Is disclosing & expressing[10] and Feels trusting & relying [18]	Is attacking & rejecting [7] and Feels constrained & helpless [29]
en	To be affirming & understanding [3] and To be loving & approaching [5]	Is ignoring & neglecting [8] and Is walling off & distancing [16]	Is asserting & separating [9] and Feels disgusted [31]
n	To be affirming & understanding [3] and To be trusting & relying [23]	Is freeing & forgetting [1] and Is ignoring & neglecting [8]	Is sulking & scurrying [14] and Feels disgusted [31]
n	To be loving & approaching [5] and To be joyfully connecting [21]	Is affirming & understanding [2] and Feels friendly [18]	Feels disgusted [31] and Is self-accepting & exploring [33]
ah	Other to be affirming & understanding me [4] and To be asserting & separating [17]	Is watching & controlling [5] and Feels powerful [21]	Is deferring & submitting [13] and Feels constrained & helpless [29]
a	To be freeing & forgetting [1] and To be joyfully connecting [21]	Is walling off & distancing [16] and Feels hostile & angry [23]	Feels annoyed & irritated [22] and Is self-monitoring & restraining [36]
n	To be disclosing & expressing [19] and Other to be disclosing & expressing me [20]	Is ignoring & neglecting [8] and Feels annoyed & irritated [22]	Feels constrained & helpless [29] and Is self-monitoring & restraining [36]
or	Other to be affirming & understanding me [4] and Other to be nurturing & protecting me [8]	Is belittling & blaming [6] and Feels powerful [21]	Feels powerful [21] and Feels disgusted [31]
	To be freeing & forgetting [1] and To be asserting & separating [17]	Is watching & controlling [5] and Is ignoring & neglecting [8]	Is self-disclosing & expressing [10] and Is self-indicting & oppressing & guilty [37]
s	To be nurturing & protecting [7] and To be disclosing & expressing [19]	Is attacking & rejecting [7] and Feels hostile & angry [23]	Is walling off & distancing [16] and Feels apathetic [24]

Table 3 Early phase of therapy primary CCRT-LU formulations for all patients

Patient	EARLY PHASE OF THERAPY		
	WISH	RESPONSE OF OTHER	RESPONSE OF SELF
1 Quin	C2 Loving, Having relationship	L1 Annoying someone	F2 Being scared, Anxious
2 Gerta	A2 Accepting, Understanding	J2 Opposing, Criticising	F2 Being scared, Anxious
3 Sally	D2 Being proud, Being autonomous	K2 Dominating	H2 Being disliked
4 Artie	C1 Being close	J2 Opposing, Criticising	F2 Being scared, Anxious
5 Quoit	B2 Helping, Giving independence	J1 Ignoring, Reproaching	H1 Feeling disgust, Being angry
6 Carla	A2 Accepting, Understanding	I1 Neglecting	G2 Being Weak
7 Amal	D2 Being proud, Being autonomous	K2 Dominating	F2 Being scared, Anxious
8 Troy	A2 Accepting, Understanding	J2 Opposing, Criticising	F1 Feeling guilty, Being dissatisfied
9 Karen	A1 Exploring, Admiring	J2 Opposing, Criticising	J2 Opposing, Criticising
10 Ken	D2 Being Proud, Being autonomous	J1 Ignoring, Reproaching	G2 Being Weak
11 Kim	C4 Being sexually active, Interested	C4 Being sexually active, Interested	F2 Being scared, Anxious
12 Leah	C2 Loving, Having relationship	K2 Dominating	F1 Feeling guilty, Being dissatisfied
13 Tara	C1 Being close	I1 Neglecting	C3 Being confident, satisfied, experiencing pleasure
14 Wyn	D2 Being proud, Being autonomous	K2 Dominating	F2 Being scared, Anxious
15Victor	D1 Being moderate, Trustworthy	I1 Neglecting	H1 Feeling disgust, Being angry
16 Sue	B1 Explaining, Confirming	I1 Neglecting	G2 Being Weak
15 Kris	C1 Being close	J2 Opposing, Criticising	G2 Being Weak

Appendix E

Listing of the seventeen patients, including residual change in Mastery Scale scores

Patient Number	Patient Name	Patient Gender	Patient Age	Residual Change in Mastery Scale Score	Rank Order of Improvement [1=most improved, 17=least improved]	Description of Improvement
1	Quin	Female	29	.27	9	Mixed
2	Gerta	Female	35	.79	3	Most
3	Sally	Female	25	.41	6	Most
4	Artie	Male	65	.92	2	Most
5	Quoit	Female	31	.77	4	Most
6	Carla	Female	38	.42	5	Most
7	Amal	Female	52	-.41	13	Least
8	Troy	Male	22	1.96	1	Most
9	Karen	Female	34	.35	7	Mixed
10	Ken	Male	32	-.21	12	Least
11	Kim	Male	33	-1.21	15	Least
12	Leah	Female	28	.11	10	Mixed
13	Tara	Female	30	.27	8	Mixed
14	Wyn	Female	45	.002	11	Mixed
15	Victor	Male	34	-1.21	14	Least
16	Sue	Female	31	-1.50	16	Least
17	Kris	Male	32	-1.76	17	Least

Appendix F

Contingency Table of Kappa Calculations for Agreement Between the QUAINT and CCRT-LU Systems

QUAINT	CCRT-LU																														T
	A1	A2	B1	B2	C1	C2	C3	C4	C5	D1	D2	E1	E2	F1	F2	G1	G2	H1	H2	I1	I2	J1	J2	K1	K2	L1	L2	M1	M2	M3	
A1																															0
A2	//	///			/		/	/		//									/			/	/		/						14
B1											/												/								2
B2					/																										1
C1				/							/																				2
C2				/	//			//			///																				8
C3					/	/	/				////												/								9
C4																															0
C5																															0
D1																															0
D2			/	/		/	/				///			/	/			///					/								13
E1															/																1
E2																		/													1
F1																	/														1
F2														/	//		/														4
G1																		/													1
G2														/	//		////		/			/			/						10
H1					/		/							/	/		/	///		/		//									11
H2															/																1
I1															/		/			//											4
I2																															0
J1																		/				/	/		/			/			5
J2	/			/	/													/		/			/								6
K1																				/											1
K2	/	//	/					/			/	/								//		/	//		////	//					18
L1																		/													1
L2																							//								2
M1		/									/	/			///		///	/		/			//								13
M2																															0
M3																															0
T	4	6	2	4	7	2	4	4	0	2	15	2	0	4	12	0	11	12	2	8	0	7	11	0	7	2	0	1	0	0	129

The following table lists the translated QUAINT into CCRT-LU categories and the CCRT-LU categories for each patient, each component per phase of therapy. These categories were transcribed to the QUAINT x CCRT-LU contingency table (on following page) required for the kappa calculations.

Patient	W		RO		RS	
Phase	QUAINT	LU	QUAINT	LU	QUAINT	LU
1E	C3	C2	K2	L1	I1	F2
1M	D2	B2	I1	G2	G2	G2
1L	C1	B2	I1	I1	G1	H1
2E	A2	A2	J1	J2	F2	F2
2M	--	*C3*	--	*K1*	--	*F2*
2L	M1	D2	L2	J2	M1	F2
3E	C2	D2	K2	K2	G2	H2
3M	D2	D2	K2	K2	G2	H2
3L	K2	D2	K2	J1	H1	H1
4E	A2	C1	K2	J2	G2	F2
4L	C3	D2	C2	C4	C3	C3
5E	C2	B2	H1	J1	J2	H1
5L	C2	C1	H1	C1	M1	F2
6E	K2	A2	H1	I1	H1	G2
6M	K2	A2	K1	I1	F2	G2
6L	M1	A2	K2	E1	M1	E1
7E	D2	D2	G2	K2	M1	F2
7L	C1	D2	K2	K2	D2	H1
8E	A2	A2	B1	J2	G2	F2
8L	A2	A2	A2	C3	D2	C3
9E	K2	A1	J2	J2	M1	J2
9M	A2	A1	J2	I1	H1	F1
9L	C2	D2	J2	B2	D2	H1
10E	C3	D2	J1	J1	G2	G2
10M	C3	D2	A2	J2	M1	G2
10L	C3	D2	A2	H2	D2	F2
11E	C2	C4	A2	C4	H1	F2
11M	K2	B1	D2	J1	J1	M1
11L	J2	C1	A2	J1	H1	L1
12E	D2	C2	K2	K2	D2	F1
12M	J2	A1	G2	J1	E1	F2
12L	C2	D2	K2	L1	F2	F2
13E	C3	C1	M1	I1	H1	C3
13M	--	*C1*	--	*J2*	--	*H1*
13L	A2	A1	I1	I1	H1	H1
14E	B1	D2	J1	K2	G2	F2
14M	--	*A2*	--	*I1*	--	*F1*
14L	D2	D2	E2	H1	H2	F2
15E	A2	D1	K2	I1	H1	H1
15M	C3	D2	K2	J2	J1	H1
15L	A2	K2	M1	H1	F2	F1
16E	D2	B1	K2	I1	F1	G2
16M	A2	D1	K2	C4	G2	G2
16L	--	*D1*	--	*J1*	--	*F2*
17E	B2	C1	L2	J2	M1	G2
17M	C2	C1	M1	J2	M1	G2
17L	C3	J2	H1	J1	D2	H1

Appendix G

Figures from second study on the average Harmony across therapy, at the CCRT cluster level of analysis

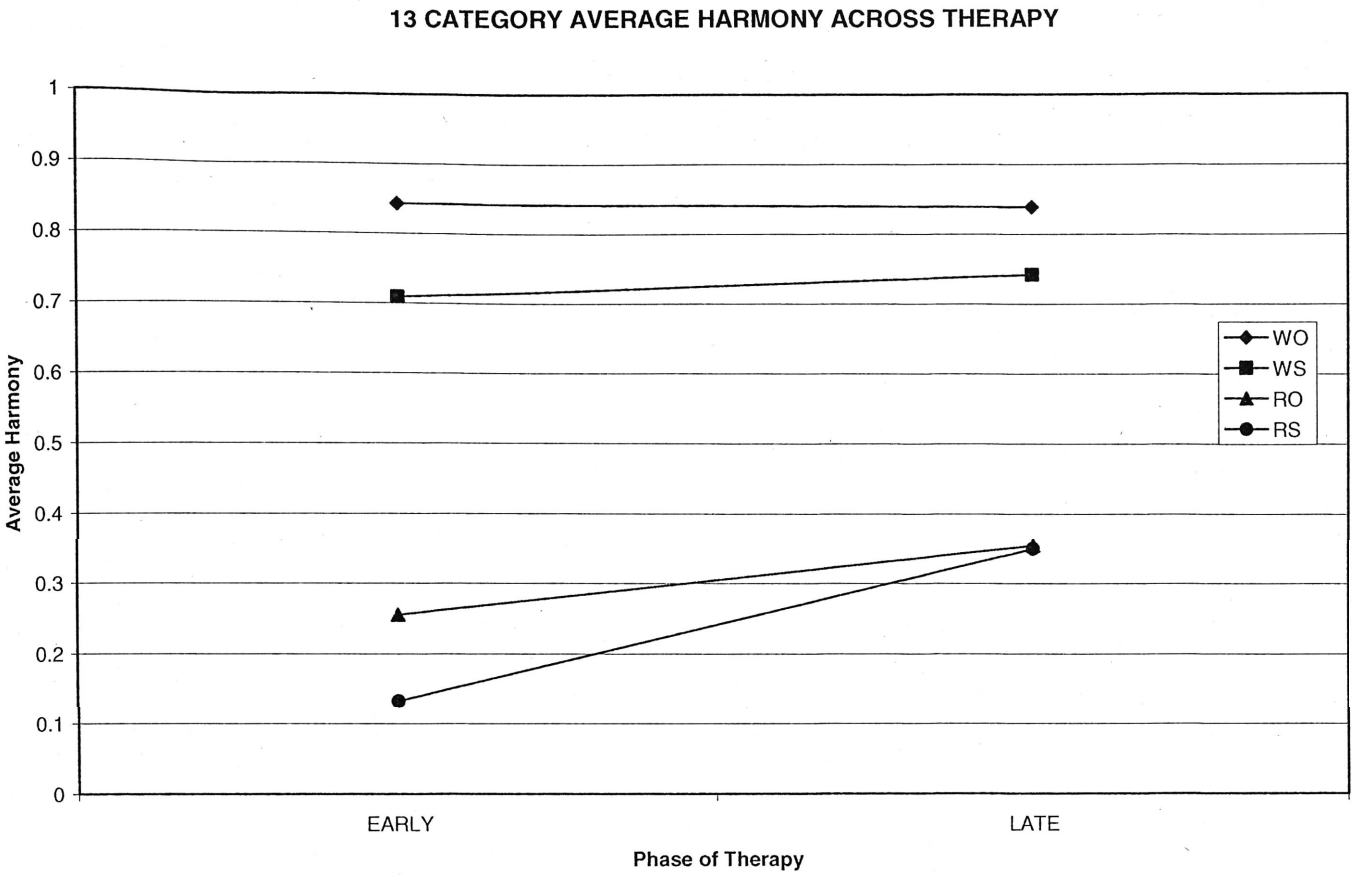


Figure 1 Average harmony across two phases of therapy for 17 patients

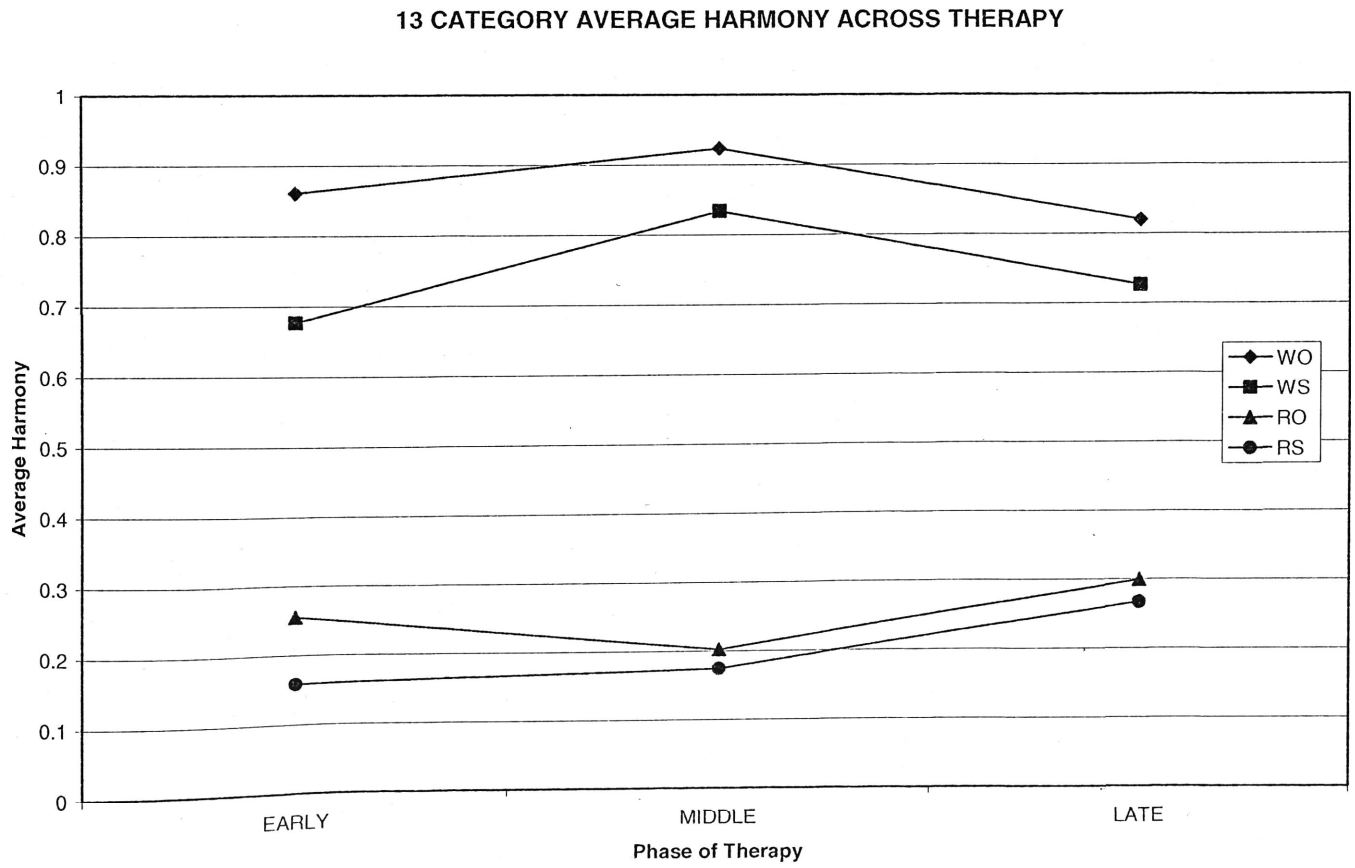
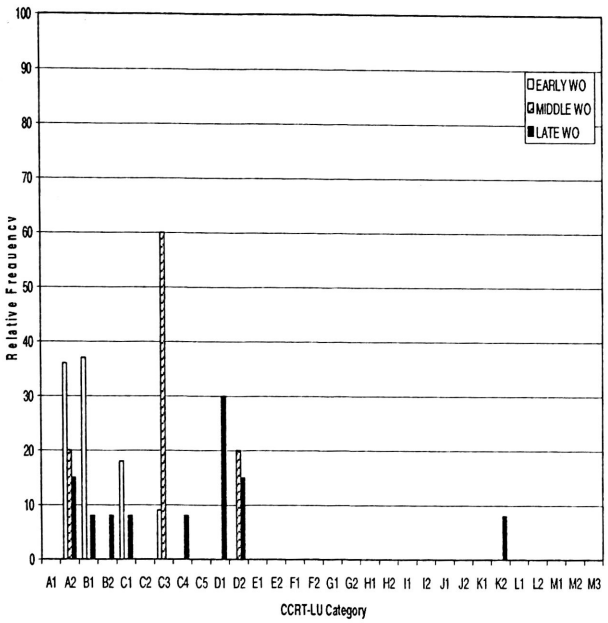


Figure 2 Average harmony across three phases of therapy for 13 patients

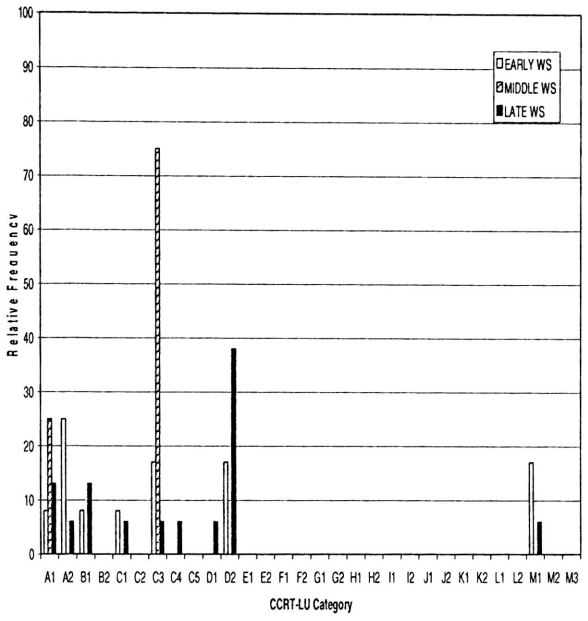
Appendix H

Distribution of CCRT-LU Categories for Patients Gerta, Karen and Kim

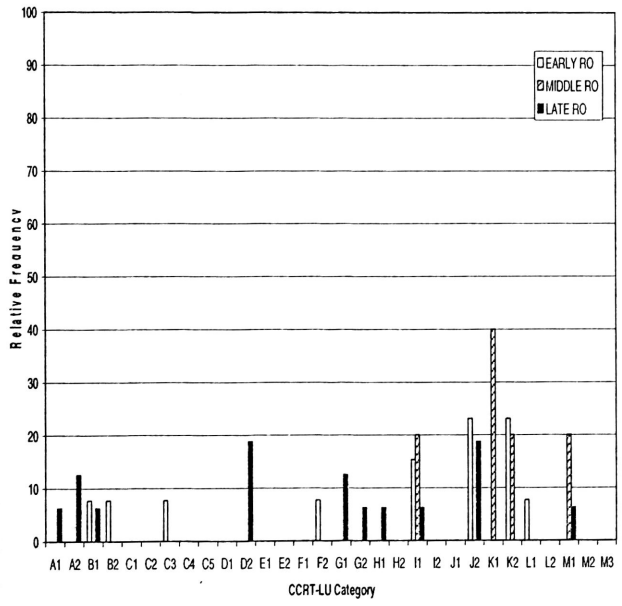
PATIENT 'GERTA' EARLY vs MIDDLE vs LATE WO



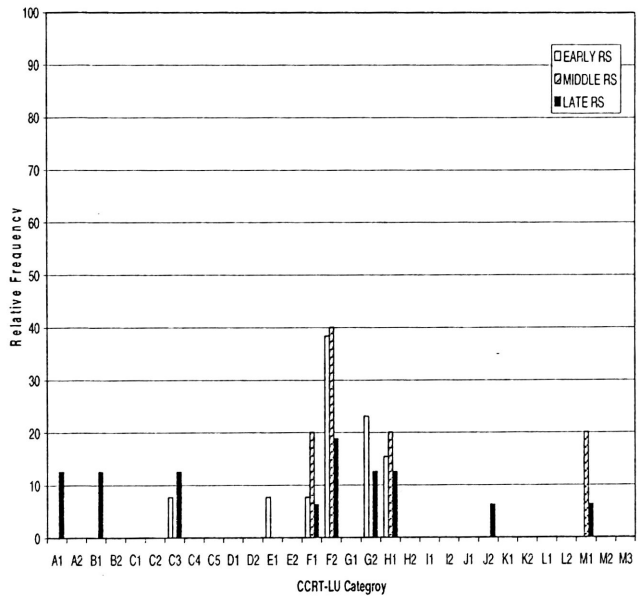
PATIENT 'GERTA' EARLY vs MIDDLE vs LATE WS



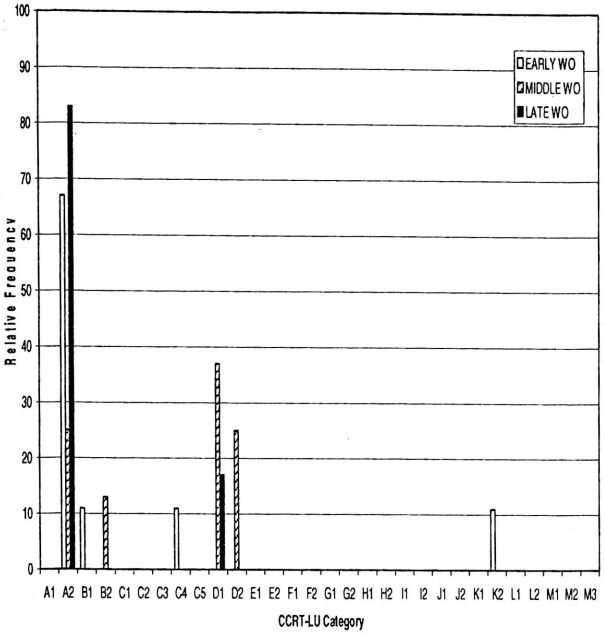
PATIENT 'GERTA' EARLY vs MIDDLE vs LATE RO



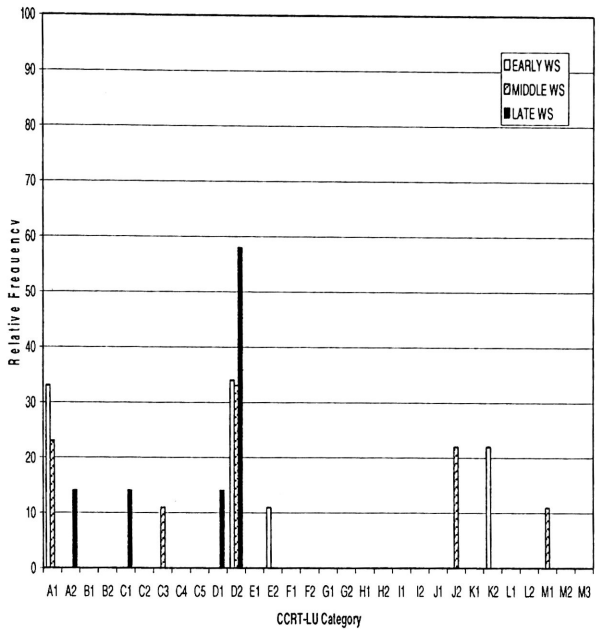
PATIENT 'GERTA' EARLY vs MIDDLE vs LATE RS



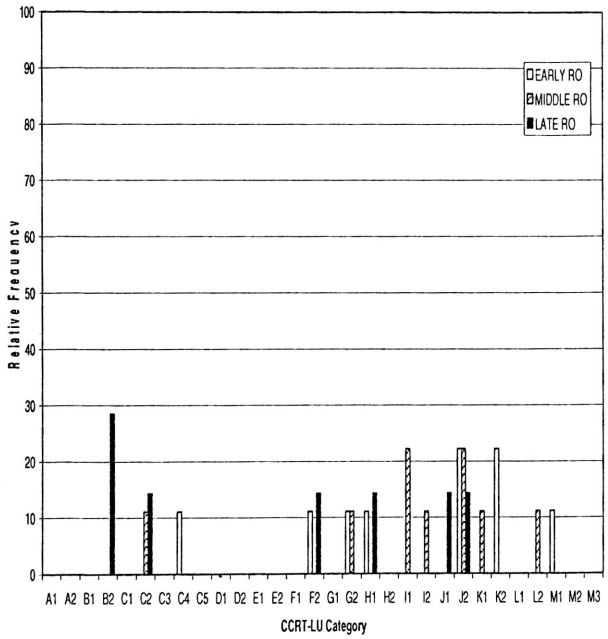
PATIENT 'KAREN' EARLY vs MIDDLE vs LATE WO



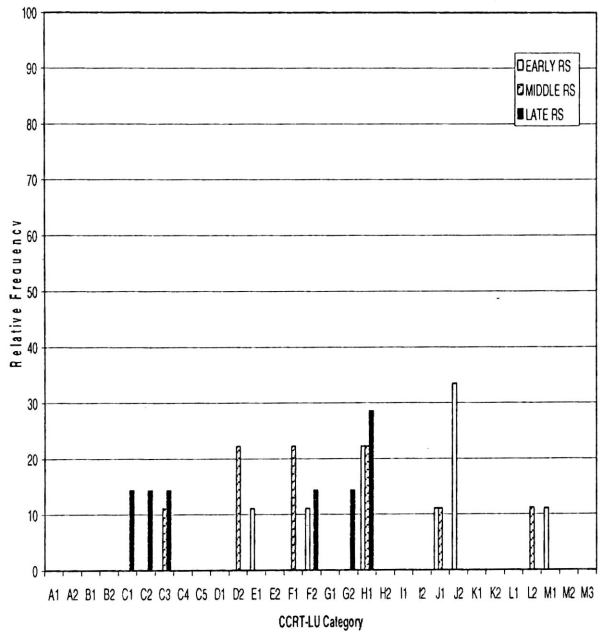
PATIENT 'KAREN' EARLY vs MIDDLE vs LATE WS



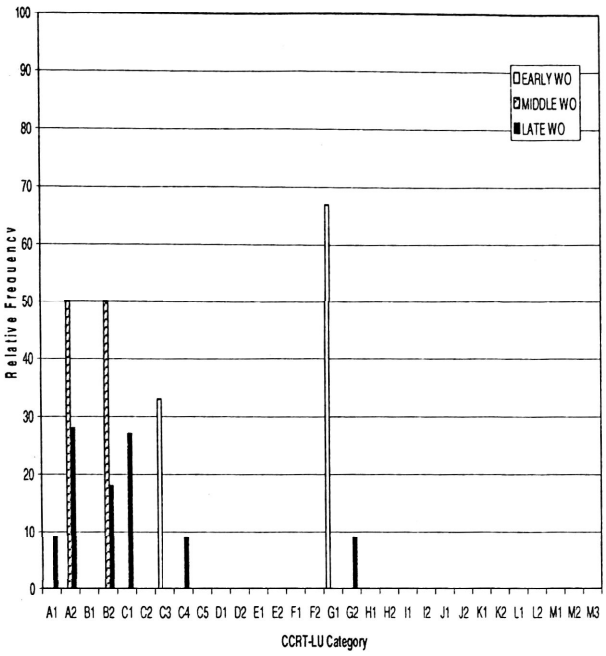
PATIENT 'KAREN' EARLY vs MIDDLE vs LATE RO



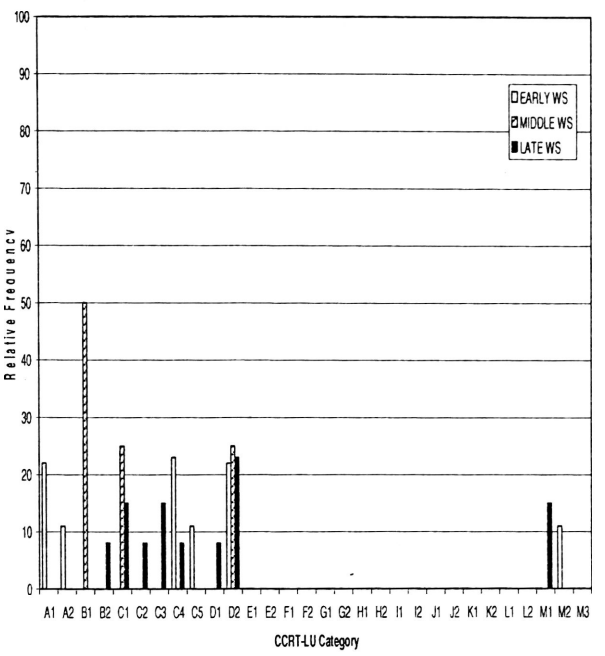
PATIENT 'KAREN' EARLY vs MIDDLE vs LATE RS



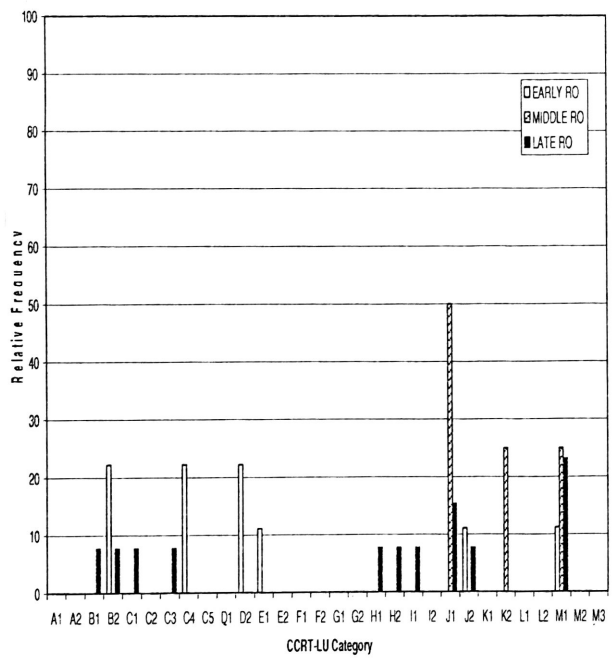
PATIENT 'KIM' EARLY vs MIDDLE vs LATE WO



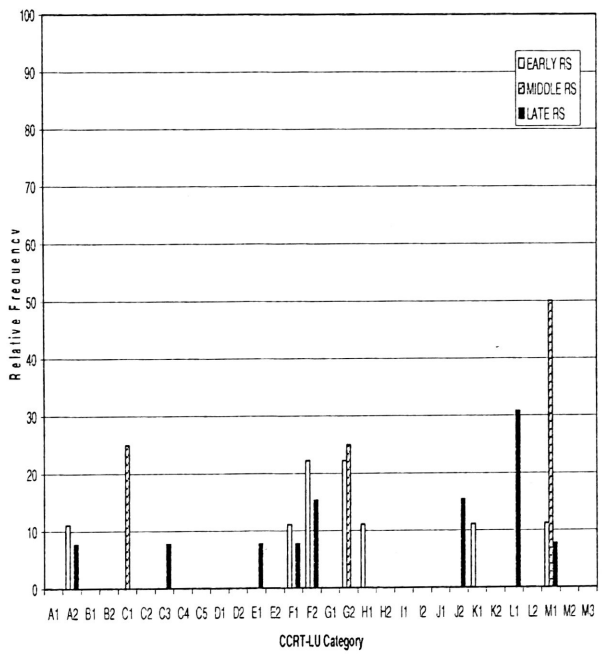
PATIENT 'KIM' EARLY vs MIDDLE vs LATE WS



PATIENT 'KIM' EALRY vs MIDDLE vs LATE RO



PATIENT 'KIM' EARLY vs MIDDLE vs LATE RS



BETTA BOOK BINDING
& PRINTING
Michelle & Darren
26 Field St, Kanahooka
Ph (02) 4261 2998 • 0414 612 990
Email: bettabooks@catchnet.com.au